Certificate of Death

Reg. No.

10:45 PMM

10d. Inside City Limits

Approximate Interval Between Onset and Death

Month

29d. Date signed (Month, Day, Year)

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

1√2 Yes 2 □ No

Maryland

2. Date of Death

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Decedent's Name (First, Middle, Last)

LILLIAN

DHMH 17 Rev 1/2001

Registrar

within 24 hours e To the Funerel [

0

Medical

29a, Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DR. TARIQ MAHMOOD

APR 2 1 2006

2300 DULANEY VALLEY RD.

. Registrar's Signature

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

TIMONIUM, MD 21093

Amend Item: 2 per M.D G-855 5/18/06 reb Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 17
Month: Day 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 7:50 alson 200 ames /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Ve amon 7. Age (In yrs. last birthday)
Yrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days 242-3314 10(M 2□ F Carolina Director North Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "naturel", or Iteme 23a or 28a-f show somy injury or other traumatic event, the Medical Exeminational Department at 2008. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Varyland 10e. Street and Number mor 10f. Zip Code 10g. Citizen of What Country? 2 non Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) . Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ 19a. Informant's Name/Refationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) lwite, 2463 Se 20b. Place of Disposition (Name of anion Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place)

Roan oke Chape

22. Name and Address of acitity

55eph

Russell Burial 2 ☐ Cremation 3 ☐ Removal from State 200 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Home, P.A Ave. Balto, Md Willorth 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lung aucen **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physicien and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown s been signed by the should be detact Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy certificate 2□ No 1 🗌 Yes Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Inpatient 2 ER/Outpatient 3 DOA this After this 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 🗌 Yes 2 No 2 Accident Director: 3 🗌 Suicide 6 □ Could not be 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide within 24 hours a To the Funerel [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier

State Registrar

31. Date filed (Month, Day, Year) APR 2 1 2006

29b. Signature and title of certifig

BCHOMP 13001 South Hayover St, Baltimore, Up

and manner stated

30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

D24632

29d Date signed (Month, Day, Year)

		1 - State Registrar Amend #20b	State of Ma Per FH g8	ryland / [355 5/9/	Departme <i>Gertific</i>	ent of He ate of D	ealth and M leath		giene Reg. No.	6	12503
Physici		1. Decedent's Name (First, Middle, Last)	Alice Ma					2, Date of De Month A	_{Day} pril 17, 200	Yeer 6	3. Time of Death 3:00 p.m. M
/Medio Examir		4a. Facility Name (If not institution, give s. Sunrise As	reet and number) sisted Living	of Columbi		ty, Town, or L	ocation of Death	umbia	4c. County		ward
Funeral Director		5. Social Security Number 6. Sex		(In yrs. last bir		der 1 Year ns Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, De September		9. Birthp Cour	place (State or Foreign htry)
Aaryland I show	or	Usual Residence of Decedent 10a. State 10b. County Maryland How	vard	10c. City, Tow	n or Location	Co	olumbia			1	0d. Inside City Limits
h with the N 13a or 28a-	al Director	10e. Street and Number 6500 Freetown Rd.	iaia		10f.	Zip Code	21044		10g. Citizen of \	What Cou	
ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23e or 28e-f show or other traumatic event, the Medical Exprinter must be inclined at	by Funeral	11. Marital Status 1 1 Never Married 2 Married 3 Widowed 4 Divorced	 Was Decedent I Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates: 		If Yes,	cedent of His pecify Cuban s 2 No	panic Origin? (Sp , Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		ck, White,	can Indian, etc. White
within 72 hounde.	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5		Decedent's U (Give kind of life. DO NO	work done du Tuse retired)	ion iring most of work se Secretary		16b, Kind of B		dustry
IGING & Jid be filed v Jental Hygie rked other t	To Be Co	17. Father's Name (First, Middle, Last) Arthur [18. Mother's Nam	e (First, Middle	, Maiden Suman ine Cathalo		
nd 2 should be a s		19a. Informant's Name/Relationship (Type Mrs. Mary Alice Mause					nd Number or Run Or, Glenwood			State, Zip	o Code)
L Se		20a. Method of Disposition 1 🗷 Burial 2 □ Cremation 3 □ Ri 4 □ Donation 5 □ Other (Specify)	emoval from State	cemete	f Disposition <i>(</i> ry, crematory ngton Nati	or other place	06/07/ netery	0.	20c. Location		own, State , Virginia
permit. Departmit importa		21. Signature of Funeral Service Libense	while	t mors	3	3871 O	uneral Home d Columbia	Pike Ellico		21043	
Physician /Medical Examiner		23a. Part1. Enter the discusse, or complications, or chart failure. List only on immediate Cause (Final disease or condition resulting in death)			umon		, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
of out, ate be executed hysician and the burial-transit	dlcai Examiner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a consequence							
w requires that the death certific been signed by the attending p should be detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1 Yes 2 2 No 9 Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 □Ectop 5 □ Other	c pregnancy (specify)				ate of deliventh	ery Day Year
w requires that the second of	þ	Part II. Other significant conditions con		•	in the underlyi	ng cause give	n in Part I.			•	the cause of death?
The law ate has b page 2 sl	Completed							24a. Was auto perfi 1 Yes	s an 24b. psy prmed? 22 No	Were autoprior to codeath?	opsy findings available ompletion of cause of
Attanding Physician: The result. The death. Control After this certificate by the funeral director, page	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1-Natural 5 Pending 2 Accident Investigation	ospital: 1 Inpatie 28a. Date of Inju (Month, Da		utpatient 3 Time of Injury	28c. Injury Work	at Nursing no	ome 5 Res		ner <i>(Speci</i>	HSSISKED
그 하는 그 그	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	ury - At home, fac. (Specify)	arm, street, fa	ctory, office		28f. Location (City or To	(Street and Num. wn, State)	ber or Rui	al Route Number,
L To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examination	ner: On the basis o	f examination as	nd/or investiga	tion, in my op	inion, death occur	rred at the time.	, date and place,	and due	to the cause(s)
To the P within 2. To the F complet	×	29b. Signature and title of certifier	W			29c. License	number -53636 Unmbic		April	ed (Month	2006
6		30. Name and address of person who co	empleted cause of o	death (Item 23a)	(Type, Print)	e Co	lumbic	MO	21044		
St Regist	ate rar	31. Date filed (Month Cay Year) 200	Registr	ar's Sign ture	Agerta		·				

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) A\bulletil 1\bullety 200\text{6" Physician MAry Ann Germano 6:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Essex 1000 Franklin Ave. ff Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 4,1925 Maryland Months 1 ☐ M 2 🛣 F MArch. 218-16-1817 81 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits 28a-f show other treumatic event, the Madical Examiner must be notified at Essex 1 Tyes 2 XNo MD Baltimore Director 10f Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21221 1000 Franklin Ave. Iteme 23a Funeral 12. Was Decedent Ever in U.S. Amed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status e filed within 72 hours after di It Hygiene. other than "naturel", or Item Bfack. White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Health Elementary/Secondary (0-12) College (1-4or 5+) Nurse 12th permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 Is marked other eny injury or other treumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alberta Michaels Theodore Ballala 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4236 Federal Hill Road Street MD Salvatore Germano / son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bayview Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Tremation 3 Removal from State Baltimore MD 4 □ Donation 5 □ Other (Specify) 06 22. Name and Address of Facility 300 Mace Ave. Baltimore MD 21. Signature of Funeral Service Licensee Connelly Funeral Home of Essex Om fications that caused the death. 23a. Part1. Enter the disease, or comshock, or heart failure. List anily not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Due to (or as a consequence of). n any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner the attending physician and hed for use as the burial-transit the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23d. Date of delivery $\mathcal{U}\mathcal{A}$ 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetaf death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 20 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t director, page 2 s autopsy performed 1 Yes 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Pface of Death (Check only one) Other: 4 Nursing Home ို 1 ☐ Yes 2 No 1 Inpatient 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 5 Pending VIA 1 ☐ Yes 2 ☐ No 2 Accident investigation М N14 NIA 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide N 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier oleted cause of death (Item 23a) (Type, Print) tantord Rd. B 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 6

			For State Registrar	State of Maryland	Certificate of Death	Nernai mygien Reg. N	1000
	Physici	an	1. Decedent's Name (First, Middle, Last	or Gol	haa	2. Date of Death	3. Time of Death 12:32 Am
)	/Medio Examin		4a. Facility Name (If not institution, give	street and number)	Do. City, Town, or Location of Deat	h 4	Ic. County of Death
Ī	Funeral Director		5. Social Security Number 6. Sec. 10	7. Age (In yrs. Ias	st birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min.		9. Birthplace (State or Foreign Country)
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lacation		10d. Inside City Limits
	8a-fsh	ector	mo	Ba	Itimore	10.0	1@Yes 2 No
	death with the Maryland ms 23a or 28a-f show rmust be rediffed at	Dire	10e. Street and Number	rd Apt	9A 2/2/7	10g. C	Citizen of What Country?
036	2 should be filed within 72 hours atter death with the Marylar and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show emailic event, Ita Madical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 Yes 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: KOYCOM
215-0036	n 72 ho "natur	Completed	15. Decedent's Edu (Specify only highest grad	de completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)	rking 16b.	Kind of Business/Industry
2	ygiene. ygiene. ner than	Comp	Elementary/Secondary (0-12)	College (1-4or 5+)	Homemaker		at Home
land	should be fill ind Mental H marked ott	To Be	17. Father's Name (First, Middle, Last),	on Goh	na Go	me (First, Middle, Maide M VIII)	a Chang
Maryland	カニトン		19a. Info ant's Name/R tionship (T	ype, Print) (Son)	19b. Mayling Address Street and Number or Ri	ural Route Number, City	dr Town, State, Zip Code)
	permit. Peges 1 and Department of Heelth Important: if item 27 sny Injury or other tr		20a. Method of Disposition 1 Surial 2 Cremation 3	20b. Plac	ce of Disposition (Name of netery, crematory or other place)	Date 20c.	Location - City or Town, State
Baltimore,	nit. Peges artment of ortant: if it Injury or o		4 Donation 5 Other (Specify, 21. Signature of Funeral Service License	mer	22. Name and Address (Facility	21/06	Imonium, mD
ñ	permit. Departr Imports sny Inj		Rennett	- Amh	Cremation center		onion, mo 21093
	Physician		Immediate Cause (Final	lications that caused the death. ne cause on each line.	Do not enter the mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between Onset and Death
Ì	/Medical Examiner		disease or condition resulting in death)	Due to (or as a consequen			7 71. 61. (4)
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or at a conseque	nice of):		
,	tificate be executed g physicien and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequent	ince of):		
68760,	cate be physicie the bur	edical		d			
.O. Box 6	The law requires thet the death certifi sie hes been signed by the ettending cege 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 □/No 9 □ Unknown	23c. If yes, outcome of pregnanc 1 ☐ Live birth 2 ☐ Fetal di 4 ☐ Pregnant at time of deal 9 ☐ Unknown	leath 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
٥.	w requires thet been signed by should be deta	Ď	Part II. Other significant conditions co	intributing to death but not resulti	ing in the underlying cause given in Part I.		o use contribute to the cause of death?
Vital Records,		Completed				24a. Was an autopsy performed? 1 ☐ Yes 250	
	ysician: The is certificete hi director, pege	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ EF	Other	ath Check only one	6 □Other (Specify)
o uc	£ 5 =		27. Manner of Death 1 Natural 5 Pending	(Month, Day Year)	28b. Time of Injury al Work?	28d. Describe how in	jury occurred
Division of	i or Attending Peffer death. Director: Affer i in by the funera	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ne, farm, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
_	To the Hospital or Atten within 24 hours efter deatl To the Funeral Director: completely filled in by the	Medical C			ledge, death occurred at the time, date and place on and/or investigation, in my opinion, death occ		
•	To the within 2 To the complet	M	29b. Signature and title of certifier	Leffer	29c. License number	29d. [Date signed (Month, Day, Year)
į		1	30. Name and address of person who c	completed cause of death (Item 2	23a) (Type, Print) 2001 South Hall	never st	Balt, 21777 Balt, 21777
	Sta Regista		31. Date filed (Month, Day, Year)		y Agashi		
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,			1. Decedent's Name (First, Middle								2. Date of De Month	eath Day	Yea	r	of Death
	Physicia /Medic	_		LEN HELTON			,				APR 9				55 A M
	Examin		4a. Facility Name (If not institution,						Location of	of Death		4c. C	County of De		
			NATIONAL NAVAL					BETH 1 Year	ESDA If Under	24 Hrs	8. Date of Bir	dh		GOMERY	la ar Faraiga
	Funeral Director		5. 215 - 75 4939 N/A	6. Sex 1X M 2 F 7.	. Age (In yrs.	last birthday) Yrs.	Months	Days	Hours 1	Min	April	av. Year)	06 Ma	lirthplace (Stat Country) ryland	e or Poreign
	pur A		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							10d. Inside	City Limits
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	286-1	rect	Maryland Charl 10e. Street and Number	<u>es</u>	Del	ALLOI		Code				10g. Citiz	en of What	Country?	
	3a or	Funeral Director	9120 Crain High	wav			20	0611				U.S	.A.		
	death ms 2	Jer	11. Marital Status	12. Was Deced	ent Ever in U	I.S. 13.	Was Dece	dent of Hi	spanic Ori	gin? (Sp	ecify Yes or No Rican, etc.)	0- 1-	4. Race - Ar Black, W	merican Indian	
٥	or items		1 X Never Married 2 ☐ Marri	Armed Force ied 1 ☐ Yes 2 If Yes, Give	Ν̈́ο		1 ☐ Yes						Specify:		
3	hours after death with the Maryland tural, or Items 23a or 28e-f ehow al Examiner outs be notified at	d by	3 Widowed 4 Divorced	Year or Dat	es:								W	hite	
7	72 h	ete	15. Decedent (Specify only highes	t's Education of grade completed)		16a. Dece	dent's Usu kind of wo DO NOT u	rk done d	<i>turing</i> mos	t of work	ing	160. Kin	d of Busine:	ss/industry	
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	e filed w al Hygier I other ti vent, th		17. Father's Name (First, Middle,	Last)					18. Mothe	ər's Nam	e (First, Middle	, Maiden S	Surname)		
a	Mental Mental arked o	To Be	Chad Allen Hel	ton, Sr.					Che:	lsea	A. Bur	ns			
Maryland	s 1 and 2 should to the stand Menity Health and Menitiem 27 is markey other traumatic	۲	19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ng Addres	s (Street a	and Numbe	er or Rur	al Route Numb	oer, City or	Town, State	, Zip Code)	
	and 2 eaith a m 27 la	1	Chad A. Helton	(Father)		9120	Crain	ı Hwy	. Ве	e1 A	lton, M	D 206	11		
e e	of He item		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	2 □Bomoval from St	1	Place of Displ cemetery, cre	osition (Na matory or	me of other plac	e)		Date	20c. Loc	ation - City	or Town, State)
Ĕ	Pages nent of sint: If it		4 □ Demation 5 □ Other (S)		Ve	nice C				4/28			s, Oh	io	
Baltimore,	permit. Pages 1 Department of H Importent: If Ite eny Injury or otl		21. Signature of Funeral Service	Licensee		2	2. Name a Charl	nd Addres	s of Facili	ing .	Funeral	Home			
<u> </u>	20E = 9	V (7)	23a. Part1. Enter the disease, or	VIII	re_		P.O.	Box	128,	Ros	s, Ohio	4506	1	Approxir	
,09/	Physician /Medical Examiner Approximately transit Physician and Physician Physician	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (o	MATURI r as a consec r as a consec r as a consec	quence of):									nd Death
.O. Box 68	death certifica e attending ph ed for use as th	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2□Fet nt at time of	al death 3	⊒Ectopic p □ Other (s		,			2	3d. Date of Month	delivery Day	Year
<u>ഗ്</u> ച	Physician: The law requires that the de r this certificate has been signed by the a ral director, page 2 should be detached	δ	Part II. Other significant condition	ons contributing to dea	ath but not re	sulting in the	undertying	cause giv	en in Part	l.		tobacco us		Probably 4	
ord	w require been sig	eted									24a. Wa				
Records,	he law e has i	Completed									auto	opsy formed?	death	autopsy findir to completion ? 'es 2 No	of cause of
	infication, pa	C	25. Was case referred to medica:	1					26. Ptac	e of Dea	1 ☐ Yes		,,,,	03 20110	
>	ysicie s cert direct	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	patient 2	ER/Outpatie	ent 3 D	OA Oth	er: 4 □ N	ursing H	ome 5 Res	sidence 6	Other (S	pecify)	
5	ter th		27. Manner of Death 1 XNatural 5 ☐ Pendin	28a. Date of	Injury , Day Year)	28b. Time	of	28c. Injur Wor	y at k?		28d. Describe	how injury	occurred		
Ö	Attending or death.	atic	2 ☐ Accident investi	gation			М	1 🗆	Yes 2	No					
Division of Vital	for Attendated after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ained 288. Place	of Injury - At I g, etc. (Spec	nome, farm, s ify)	treet, facto	ry, office				(Street and own, State)	f Number or	Rural Route N	√umber,
	urs al urs al arel D		CO. C. siding 100 Contituin	ng Physicien: To the t	ant of my lea		th converse	d at the tie	no data a	nd place	and due to the	e cauce(c)	and manner	heteta as	
	To the Hospitel or Attending Physician: The i within 24 hours after death. To the Funarel Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier 1 (X) Certifyir (Check only 2 Medical one)	Examiner: On the bas and manner	sis of examin	ation and/or i	nvestigatio	n, in my o	pinion, de	ath occu	red at the time	, date and	place, and	due to the caus	se(s)
	o the	Me	29b. Signature and title of certifie				29	c. Licens	e number			29d. Date	signed (M	onth, Day, Yea	ır)
	⊢ \$ ⊢ δ		1 White	Wash "	10-			0101	23748	38 (1	JA)	4	11110	06	
•	27		30. Name and address of person	who completed cause	of death (Ite	m 23a) (Type	, Print)				AVAL ME	DICAL	CENT	ER	
	U		WHITNEY YOU I	LT MC USN				BE	THESI	DA M	20889	-5600			
363	્ક Sta		31. Date filed (Month, Day, Year)	32. Re	gistrar's Sigr	nature	A . A.	E							
	Regist	rar	APR Z	1 2006 /	200 AR 1	Alto Pa	at was	5							

					State of	Maryian		irtment of F tificate of	leaith and M <i>Death</i>		Reg. No.	6	12508
			1. Decedent's Name	(First, Middle, L	ast)					2. Dete of De	eath		3. Time of Death
	Physicia				Diana L	vnn Ha	mmon	d		Month A	Dey pril 18, 200	Year	5:40 a.
	/Medica Examine		4e Fecility Neme (If	not institution, gi					4b. City, Town, or Lo				
A				Cher	ry Lane Nurs	sina Cent	er_			urel			Georges
	Funeral		5. Social Security Nu	mber 6.	Sex . 7 1□M 2XF	. Age (In yrs.	lest birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	rth ay, Year)	9. Birthp	place (State or Foreign
ь.	Director		215-48-17	18	10 M 201	5	1 Yrs.			March 2	1955		Maryland
	Pue ≱_	ł	Usuel Residence of D	10b. County		10c. Cit	y, Town or Lo	cation		101070112	., 1000		Od. Inside City Limits
	danyt f sho	ö)						1 ☐ Yes 2 No
	the 128	2	Maryland 10e. Street end Numl		oward		<u> </u>	10f. Zip Code	Columbia		10g. Citizen of	What Cour	ntry?
	3a or	<u> </u>	07044						21045		87	U.S.	Δ
	ms 2	era	8734 Airy B	srink Lane	12. Was Deced	lent Ever in U	S. 13. V	Vas Decedent of H	dispanic Origin? (Span, Mexican, Puerto	ecify Yes or No	o- 14. Rad	e - Americ	an Indian,
0	after or he	2	1 Never Marrie	d 2 Married	12. Was Deced Armed Ford 1 Yes 2 If Yes, Give	No No	"	Yes, specify Cubi		Rican, etc.)		ck, White,	etc.
02	ral', c	<u>6</u>	3 Widowed 4	Divorced	If Yes, Give Yeer or Det	tes:		⊔ Yes ZINO	Specify:		Specif	y:	White
21215-0020	within 72 hours after deeth with the Marylend one. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	Completed by Funeral Director	(Specifi	15. Decedent's E y onfy highest gr	ducation ade completed)		16e. Deced	ent's Usual Occup kind of work done	eation during most of work d)	ing	16b. Kind of B	usiness/Ind	dustry
121	han he	2	Elementery/Second		College (1-	4or 5+)	life. L	OO NOT use retired	d)			Ref	tail
7	led v lygie nt, th	ខ្ញ	17. Fether's Name (F	12	41		<u> </u>		Clerk 18. Mother's Name	/First Middle	Maidan Sumar	ne)	
anc	tall be do	8	17. Femers Name (F	iist, Middle, Las	<i>y</i>				16. MOLITER STRAIN	•			
Ž	d Mer	ှ	19e. Informant's Nan		rd J. Hirth		10h Mailin	- Address (Ctroot	and Number or Run		orothy A. Ku		Cada
Maryland	d 2 s th an 7 is r traur		196. Informant's Nan	ne/neiationship	(Type, Film)							Siate, Elp	Codey
ē,	Heel Heel Sm 2	+	Mr. Donak 20e. Mejhod of Dispo	d Hammor	id Fr		lece of Dispos	sition (Name of	m Rd. Baltimo	Date Date	20c. Location	City or To	own, State
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryler Depertment of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.			Cremetion 3	Removal from Si	tate	emetery, cren	atory or other plac		05/0000	T:		Mandand
Ħ	nit. P entme ortan Injur	-	21. Signature of Fund		7/		Dulaney	Valley Mem	orial U4/.	25/2006	Tim	onium,	Maryland
Ba	Deperment of the sany I		Slevele	11/11/1	1.				uneral Home	, P.A.			
		\dashv	23a. Part1. Enter the	-	polications that car	used the deat	h. Do not ente	3871 C	old Columbia I	Pike Ellico	tt City, MD	21043	Approximate
-	Physician	1	shock, or heart	failure. List only	one cause on ea	ch line.			3,			1	Approximate Interval Between Onset end Death
2	/Medical		Immediate Cause (F	inal	12	0 -		^ ^ -	- 1			1	
	Examiner		disease or condition resulting in death)		a	Due to (o	r es a conseq	uence of	ER.				
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	ires that the deeth certificete be executed signed by the ettending physician end dbe detached for usa as the burial-trensit	edical Examiner	Sequentially list cond	ditions,	b. ———	Due to (o	r es e conseq	uence of):					
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Вох	eth o	Physician/M											
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Ö	been si	ere									ormed?	COI	ailable prior to mpletion of cause death?
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>	Physicien: this cartific ral director,	0 26	examiner?		Hospital:	patient 2 🗆	ER/Outpatient	3□ DOA Oth			dence 6 □Oth	er (Specifi	iv)
ō	arthis eral		27. Menner of Ceath		28e. Dete of (Month)		28b. Time of	28c. tnjur Wor			how injury occur		,,
Ö	Attending or death. ector: Aftar by the fune	a19	2 ☐ Accident	5 Pending investigation	1	, Day 1 bar/	Injury		Yes 2□No				
Division of Vital	ar de recto by th	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	286. Piece 0	f Injury - At ho	ome, ferm, stre	et, factory, office		28f. Location (er or Rura	I Route Number,
۵	rs eftar rs eftar al Direc led in by	5		,									
	To the Hospital or Attending Physicien: The lew within 24 hours effar death. To the Funeral Director: Affar this cartificeta has completely filled in by the funeral director, paga 2.	edicai	(Check only 2	Certifying Pl	miner: On the bas	is of examine	wledge, death tion end/or inv	occurred et the tin estigation, in my o	ne, date and place, a pinion, death occurr	and due to the ed et the time,	cause(s) and ma date end place,	anner as st	tated. the cause(s)
	within 2 within 2 To the F complet	2	one)	No of analting	end manne	or stated.		29c. Licens	o number		29d. Date signe	d /Month	Day Vond
	Light -		29b. Signature and tit		Tur	MD)				. /		
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	State		31. Dete filed (Month,	, Day, Yeer)	38. Rec	gistrar's Signa	ture				sel		-3 2110
	Registra			R 2 1 20		in B	Rose	E)	5217 erra#				

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiepe 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dorothy Louise Haines April 18, 2006 10:12 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 311 Woodshadows Court Millersville Anne Arundel If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Jan. 28, 5 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 ☐ M 2 🔀 F 90 213-05-6888 Director Yrs Maryland 1916 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 X No Maryland Anne Arundel Millersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 311 Woodshadows Court or itams 23a 21108 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 and 2 should be filed within 72 hours after. Health and Mental Hygiene. 8m 27 is marked other than "natural", or ital 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ White. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard G. Disneu Alziro Story 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other tra Sharon L. Stelmaszek (dghtr) 311 Woodshadows Court, Millersville, MD 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🛱 Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 4/22/2006 Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes Bucon a Wille 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) week /Medical Due to (or as a consec Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of). anding physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ģ in the past 12 months? Month 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ate has been signed | pege 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24a. Was an autopsy performed? 1 Yes 2 Who 24b. Were autopsy findings available prior to completion of cause of death? 20 No 1 Yes After this certific funeral director, Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Yes 2€No 1 ☐ Inpatient 2 ☐ ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 Tes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) use of death (Item 23a) (Type, Print) 31. Date filed 32. Registrar's Signature State Registrar

			for State Registrar	State	of Marylan		artment of F rtificate of		-	giene	6	12510
Т			1. Decedent's Name (First, Midd	ile, Last)					2. Date of De	ath Day	Year	3. Time of Death
	Physicia /Medic		Richard K. Heu	ıer						30, 2006	5	9:30 AM M
	Examin	er	4a. Facility Name (If not institution	-	ımber)			Location of Deat	h	4c. County		
			4409 Brittany 5. Social Security Number	Drive 6. Sex	7. Age (In yrs.	last hirthdayl	Ellicott		R Date of Right	Howa		de la Companya de la
	Funeral Director		367-12-9675	1 M 2 □ F	84	Yrs.	Months Days	Hours Min.		y, Year)	Illi	
			Usual Residence of Decedent		04				mai 14	, 1922	1111	nors
	yland	١. ا	10a. State 10b. Count	У	10c. Cit	y, Town or Lo	ocation				1	Od. Inside City Limits
	B Ma	cto	MD How	ard		Ellico	tt City					1 Yes 2 No
	ih th or 28	Dire	10e. Street and Number	Design			10f. Zip Code	0/0		10g. Citizen of W		ntry?
	n 72 hours after death with the Marylan "naturel", or iteme 23s or 28s=" eblow calcal Exacilmer count be notified at	Funeral Director	4409 Brittany			S 40.1		.043	N	US		
	item item	in in	11. Marital Status 1 □ Never Married 2 ☑ Ma	Armed Fo	edent Ever in U. orces?		Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puer	io Rican, etc.)		k, White,	can Indian, etc.
ב כ	urs af	þ	3 ☐ Widowed 4 ☐ Divorce	If Yes, Gi	2□No ive Dates: t43-	-45	1 ☐ Yes 2 🌠 No	Specify:		Specify	whi	.te
5	72 ho	Completed	15. Decede	nt's Education est grade completed)		16a. Dece	dent's Usual Occup	ation	rtina	16b. Kind of Bu	siness/In	dustry
<u>-</u>	thin 7	np le	Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT use retired	1)	ixing			
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2	should be filed within 72 hours after death with the Maryland nd Mental Hygene. I marked other then "naturel", or iteme 23a or 28a-f ehow umatic event, the Maulcal Exacilmer must be notified at	Be	17. Father's Name (First, Middle	-					me (First, Middle,		9)	
<u> </u>	d Mer nark natic	ဥ	Charles Henry 19a. Informant's Name/Relation			106 14-10	ng Address (Street		Stratman		C+++ 7:-	0.13
2	d 2 sl th an 17 is r traur	i	Gail Heuer/spo				Brittany					1043
บั	Heel Heel tem 2		20a. Method of Disposition	, doc	20b. P	lace of Dispo	sition (Name of		Date	20c. Location -		
	permit. Pages 1 and 2 should be filed within Department of Heelih and Mental Hygiene. Importent: if tiem 27 is marked other then any injury or other fraumatic event, its his pages.		1 ☐ Burial 2 ☐ Cremation 4 🖾 Donation 5 ☐ Other (State	emetery, crei	natory or other plac	: 0)				
	ocrter injury		21. Signature of Funeral Service Ronal		Dec	22	2. Name and Addre	ss of Facility	1 (55 11	D 1		
Ď	Depression of the control of the con		win	S Wagney	Well a	Ba	altimore,	MD 212	a 655 w. 01	Baltimo	ore S	treet
			23a. Part1 Enter the disease of shock or heart failure. Lis	or complications that	caused the deatl				c or respiratory ar	rest,		Approximate Interval Between
	Physician		tmmediate Cause (Final disease or condition	. Ca	4	Peni	c she	ock				Onset and Death
	/Medical		resulting in death)	Due to	(or as a conseq		N 1	٨				Saays
	Examiner		Sequentially list conditions,	b. <u>Co</u>	ronar	Y	Hrter	1dise	ease		_ 12	years
-	ed sit	line	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹ Due to	(or as a conseq	ue/nce of):	/					*
	xecul and al-trar	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a conseq	uence of);						
00/0	cate be executed physicien and the burial-transit	dicai E										
0	E Dog	0.3		J								
5	death certific e attending p od for use as	M/U	IF FEMALE: 23b. Was decedent pregnant		itcome of pregna		Ectopic pregnancy	,		23d. Date		*
	ed for	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of d		Other (specify)			Mor	ith	Day Year
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'n	ires the signer	þ	Part II. Other significant condit	ions contributing to d	ieath but not rest	uiting in the u	nderlying cause giv	en in Pari I.	1 🗆 Y	1/	3 ☐ Prob	ne cause of death?
	nedn	etec										
ב ב	hes ye 2 s	Completed							24a. Was autop perfo	sy p	vere auto rior to cor eath?	psy findings available impletion of cause of
9	in: The ificete or. pa	e Co	25. Was case referred to medic	al				00 Pl/ D	1 ☐ Yes	2 No 1	☐ Yes	2 □ No
>	s cert irect	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	ER/Outpatier	nt 3□ DOA Oth	or	ath <i>(Check only o</i> dome 5 X Resid		r (Specif	
5	erthii eral c		27. Manner of Death	28a. Date	of Injury oth, Day Year)	28b. Time of				ow injury occurre		<i>'</i>
202	ath. or: Aft	atio	Z L Accident	tigation	in, Day rear,	tnjury		Yes 2 □ No				
ž	r Atter de irecto	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deten	mined 286. Place	e of Injury - At ho ling, etc. (Specify	ome, farm, str	eet, factory, office		28f. Location (5 City or Tox	Street and Numbern, State)	or Or Rura	I Route Number,
2	oital o urs ef ure i D											
	To the Hospital or Attending Physician: The law requires that the death cerwithin 24 hours alter death carwithin 24 hours alter death. To the Funerei Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use	edicai	29a. Certifier 1 Certify (Check only one)	ing Physicien: To the if Examiner: On the band man	e best of my kno pasis of examina oner stated.	wledge, death tion and/or in	n occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	e, and due to the curred at the time,	cause(s) and mar date and place, a	nner as si nd due to	ated.) the cause(s)
	To t To t	Σ	29b. Signature and title of certific	1 / A	A A		29c. Licens	e number		29d. Date signed	(Month,	Day, Year)
			I ferme	tenton	/NV)		015	043		4-1	7- ()6" 2006
			30. Name and address of person		015	1 23a) (Type,	Print)	01	LD.	<1	11	I. Un
	C)		31. Date filed (Month, Day, Year	antmar	Registrar's Signa	ture	DHITIE	latuxer	it Pkw;	101-101	0	UmDia FID
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DHMH 17 Rev 1/2001

Registrar

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ā .	1. [ne (First, Middle	, Last)							2. Date of D	eath			3. Time o	of Death
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/Medical Examiner	4a.		(If not institution			ber)		4b. City, Tow	m, or Lo	cation of Death	<u> </u>	4	c. County	of Death		
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Funeral Director	1	17-26-4	Number	6. Sex	2 🗆 F	7. Age (In yrs. 76	last birthday Yrs.	Months Da		Hours Min.	8. Date of B (Month, D Jan.	ay, Year	930	Cour	place (State ntry) yland	or Foreign
DQ >	-	uel Residence d	of Decedent 10b. County			10c Ci	ity, Town or	ocation						1	IOd. Inside C	City Limits
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ed within 72 hou ygiene. In the Medical E		(Spe	15. Decedent			4or 5+)	(Giv	DO NDT use re	one duri	on ing most of work	ing	16b.	Kind of Bu			
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nd 2 shoulth and N	19		Name/Relations .ggins/G				19b. Ma 28	lling Address (St 23 Old	reet and Jopp	a Road,	Joppa,	berMity	2108	State, Zip 5	Code)	
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permit. P Departme Importan eny injur pose.		. Signature of F	Funeral Service	Licensee	11	Chi	irch C	emetery 22. Name and A Schimune	ddress c	of Facility uneral	5/06 Home of	Be	l Air	, In	с.	
	23	Ba. Part1. Enter	the disease, or	complicat	tions that ca	aused the dea	ith. Do not e	610 W. Noter the mode of	f dying,	hail Ros such as cardiac	ad, Rel or respiratory	Ai: arrest,	r, Md	. 21	() 1 4 Approxima	ate
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/Medical Examiner		sulting in death			Due to (or as a conse EKE B	quence of):	ROULA	2 1	ACCI DE	NT,	UU	LTIP	LE	1314	ONTHS
ansit	if i	equentially list of any, leading to use. Enter Und ause (Disease of at initiated even	immediate derlying or injury	<	Due to (or as a conse	quence of):	OBS 776	2VC	TIVE	LUN	a De	8t 1	SE C	OVER	5 42AC
cate be executed obysician and the burial-transit	re	sulting in death	i) Last	d	Due to (or as a conse	quence of):	ENT	8	SEPSI	15	_		Č	DVER	5 YEAR
g physi as the t				- 0						-						-
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit. Medical Certification: To Be Completed by Physician/Medical Examit	1F 23	FEMALE: b. Was decede in the past 1 1 Yes 2 9 Unknow	12 months? 2 □ No	23c	1 Live b	come of pregr inth 2 Fet ant at time of own	tal death	B∐Ectopic pregr □ Other (specii					23d. Dat Mor		ery Day	Y <i>e</i> ar
signed by d be detail	Pa	n II. Other sign	nificant condition	ons contri		ath but not re		underlying caus	e given	in Part I.					the cause of	
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tal or Attending P rs after death. al Director: After t ed in by the funera Certification:		3 ☐ Suicide 4 ☐ Homicide	6 Could		28e. Place buildir	of Injury - At I	home, farm,	street, factory, or	ffice		28f. Location City or T			er or Rur	al Route Nu	mber,
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Compl		a. Certifier (Check only one)			r: On the ba					, date and place, nion, death occur						(s)
withir To th comp		b. Signature at	ng title of Certifie	A.C.	Val	au	an	29c. L	icense r	1638	9	29d. [PRIL	(Month,	Day, Year)	06
)	30	Name and ad	tc70	who com	pleted caus	e of death (Ite	em 23a) (Typ	e, Print)	HAR	1638 FORD R	dsu.	105	FA	usi	TENH	102104
State Registrar		I. Date filed (Mo	onth, Day, Year,	1 200	6 32. 6	egistrar's Sigr	nature	well								

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			For State Registrar		State of M	larylar	-	artmer				ental Hy	gient	UU	6	125	13
8		Ť	1. Decedent's Name	(First, Middle, Last)								2. Date of De	aath Da	ıv	Year	3. Time o	f Death
	Physici /Medio	_	Richard	Charles	Jones, J	r.						April	18	3 2	006	1315	SPM
	Examir		4a. Facility Name (If			4		4b. City	, Town, or	Location	of Death		40	. County o	of Death		
200			Dinai	Hospita					altim		OA Uso			N/A			
	Funeral Director		5. Social Security No. 216-96-	4959	1M 2□ E	ge (In yrs. 41	last birthday, Yrs.	Months	Days	If Under Hours	Min.	8. Date of Bi (Month, Di July 2		964	Cour	lace (State of try) 1and	or Foreign
	pu 🔏		Usual Residence of 10a. State	Decedent 10b. County		10c Ci	ty. Town or L	ocation							1	0d. Inside C	ity Limits
	sho	7	Md.	Harford		100.0	•	1 Ai	r								2 🗆 No
	the M	ect	10e. Street and Nun			1			p Code				10a C	tizen of W	hat Cour	toy?	
	a or	늅						101. 2		1014			. og. o		S.A.	, .	
	ns 23	era	11. Marital Status	dy Circle	12. Was Deceden	t Ever in U	J.S. 13.	Was Dece			igin? (Spec	ofy Yes or N	0-			an Indian,	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show ship injury or other treumatic event, the Medical Exertime most be profiled at ADGS.	by Funeral Director		ed 2 Married 4 □ Divorced	Armed Forces 1 ☐ Yes 2√2 If Yes, Give Year or Dates	?] No		If Yes, spi	**	n, Mexicar Specify:		cify Yes or Ni lican, etc.)		Black Specify:	white,		
Ö	2 hou	ed		15. Decedent's Edu	cation		16a. Dece	dent's Ust	ual Occupa	ation			16b. I	Cind of Bus	siness/Inc	dustry	
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ğ	othe	Be C	17. Father's Name (First, Middle, Last)						18. Mothe	er's Name	(First, Middle	, Maide	n Sumame	9)		
lan	lid be lenta ked ic ev	To B	Richard	Jones, S	r.					Lil	llian	Steel	e				
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	Heal Heal tem 2		20a. Method of Disp			20b.	Place of Disp	osition (Na	me of	-1	Di	ate	20c. L	ocation - (City or To	wn, State	
Ö	ages ant of t. If i			☐ Cremation 3 ☐ F 5 ☐ Other (Specify)		9	cemetery, cre :1 Air			· 1	4/21/	06	Be1	Air	. Md		
altimore,	artme ortan injur			neral Service Licens		БС							_				
Ba	Department Department of the policy of the p		1	1111	1							ome of					
			23a, Part1, Enter th	ne disease, or compl	ications that cause	ed the dea						d, Bel		, Md	- 211	Approxima	
**	Physician /Medical Examiner	er.	Immediate Cause (disease or condition resulting in death) Sequentially list confirmly leading to implement the confirmly leading the confirmly leading to implement the confirmly leading to implement the confirmly leading the confirmation of the confirmly leading the confirmation of the confirma	<u> </u>	. 4 1	QVV s a conse	quence of):	Me	tasta	atic						Interval Be Onset and	Death
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P.O. Box 6	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-trans!	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months?	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fet	al death 3	□Ectopic □ Other (s						23d. Date Mon		•	Year
	s that ned t		Part II. Other signif	icant conditions co	ntnbuting to death	but not re	sulting in the	underlying	cause givi	en in Part I	l.	23e. Did	tobacco	use contri	ibute to th	ne cause of	death?
rds	quire n sig nid bu	Completed by	hypa	Hens!	100							1 🗆	Yes 2	? □ No	3 🗌 Prob	abiy 4	Unknown
00	w requir	jete	11									24a. Wa	s an	24b. W	Vere auto	psy findings	available
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ā	sicien: The law certificate has b irector, page 2 s		25. Was case refer	red to medical						26 Place	a of Death	(Check only	2.5 N	0 1	L Tes	2 🗆 No	
Ē	Physicien: this certification and director, i	o Be	examiner?	, II.	lospital:	tient 2	ER/Outpatie	ent 3 🗆 🖸	Oth	0.0		ne 5 Res		6 □Othe	r (Specif	v)	-
of		To To	27. Manner of Deat	-	28a. Date of In (Month, D		28b. Time		28c. Injun Worl			8d. Describe				"	
on		tior	1 Natural 2 Accident	5 Pending investigation	(Month, E	ay Year)	Injury	М		k? Yes 2 🗌	No						
Division of Vital Records,	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	ertification:	3 Surcide 4 Homicide	6 Could not be determined	28e. Place of li building,	njury - At h etc. <i>(Spec</i>	nome, farm, s	treet, facto	ory, office		2	8f. Location City or To			er or Rura	l Route Nur	nber,
	e Hospital 24 hours a e Funeral etely filled	edical C	29a. Certifier (Check only one)	1 Certifying Phy 2 Medical Exam	sician: To the besiner: On the basis and manner:	of examin	owledge, dea ation and/or i	th occurre	d at the tin	ne, date ar pinion, dea	nd place, a ath occurre	ind due to the	cause(, date ar	s) and mar nd place, a	nner as s	tated. the cause((s)
	Vithin Fo th	Me	29b. Signature and	title of gertifier				2:	9c. Licens	e number			29d. D	ate signed	(Month,	Day, Year)	
	d.			Lam	10 2	1			121	=5	00	3	An	vil 1	19	2000	
,	n		30. Name and addr	ess of person who c	ompleted cause of	death (Ite	m 23a) (Tvne	, Print)	, —	-			. 1	, ,	U		Silhma
	0		Tatio	na lar	nia	M·D	Simi	His	itali	J-Bo	Hrv	ove 2	4011	U.Bo	lveck	CAN	MO
100	St. Regist	ate	31. Date filed (Mon	-	32 Aegis	trar's Sign	ature	este	P		×1012/14/44	ove 2	• •		J(3316)	LUYTE	21215

pertent known as Richard

_			1 - For State Registrar	State of Mary			of Health and	Mental Hy	giene _{Reg. No.} 006	12514
	Physic /Medi		1. Decedent's Name (First, Middle, Las William Charles	Johnson				2. Date of De.	Day Yea	3. Time of Death 12:39 PM
	Examin Funeral Director	ner	5. Social Security Number 195-28-6899 1	iare Hosp	yrs. last birthday	Pus	ear If Under 24 Hrs ays Hours Min.	8. Date of Birt	4c. County of De Both (h, Year) 9. E 0, 1937 No.	eath TMOVE Birthplace (State or Foreign Country) TTh Carolina
0	death with the Maryland ms 23a or 28a-f show rinkal to rediffed at	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimon	1	c. City, Town or L	ocation Perry H	'all			10d. tnside City Limits 1 ☐ Yes 2 No
IAM	ter death with the Marylar Items 23a or 28a-f show instribut be politied at	ral Director	10e. Street and Number 9909 Pepper Hill	Road		10f. Zip Coo			10g. Citizen of What (•
036	72 hours after des natural', or Items d'eal Examination	by Funeral	11. Marital Status 1 ☐ Never Married 2 ◯ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates:	in U.S. 13.	Was Decedent If Yes, specify (1 ☐ Yes 2 💢	of Hispanic Origin? (S Cuban, Mexican, Puer No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - An Black, Wh Specify:	nerican Indian, nite, etc. White
) L	within ene. then *	Completed	15. Decedent's Ed (Specify only highest grad	cation de completed) College (1-4or 5+)	(Give		ccupation one during most of wor tired) MS ANALYSA		16b. Kind of Busines	·
)\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	be filed ital Hyg id other evant,	To Be Co	17. Father's Name (First, Middle, Last) William Washing	ton Johnson	Mecho	G G FOIL		ne (First, Middle,	Health Ins Maiden Sumame) Sher	arance
e, Mar	d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2		19a. Informant's Name/Relationship (T. Mrs. Mary Johnson	(wife)	9909	Pepper	Hill Road	, Perry	r, City or Town, State, Hall, MD 2	
) Saltimore,	permit. Pages 1 an Department of Heal Important: if Itam 2 any injury or other once.		20a. Method of Disposition 1 △ Burial 2 ☐ Cremation 3 ☐ I '4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Forest Service Licens	S	Db. Place of Disponentery, crest. Jose	ph Ch.	Cem. 4/24	/2006	20c. Location - City of Fullerton,	Maruland
Ba	Depa Impo any ii		Ill tella		9	705 Beli	air Rd., B	altimore	Funeral Ho , MD 21236	mes
	Physician /Medical Examiner physician and physician and physician and the pruisi-Iransil physician physici	Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of the shock of heart failure. List only of the shock of the	Due to (or as a con	requence of):	ler the mode of	dying, such as cardiac	correspiratory and	est,	Approximate Interval Between Onset and Death
30x 68760,	eath certificate be attending physici	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d		⊒Ectopic pregna	nev		23d. Date of de	
P.O. F	at the dead by the a	Physici	1 🗆 Yes 2 🗀 No 9 🗇 Unknown	4□ Pregnant at time o	of death 5	Other (specify)			Month	Day Year
ords,	w requires that the death cer been signed by the attendin should be detached for use	by	Part II. Other significant conditions con	ntributing to death but not	resulting in the u	nderlying cause	given in Part I.		bacco use contribute t es 2□No 3□P	to the cause of death?
Division of Vital Records, P.O. Box 6	: The la cate has	e Completed	25. Was case referred to medical						prior to ped? death? No 1 \(\text{Yes}	
of Vi	Physiciant this certain direct	To Be	examiner?	lospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year,	2 ☐ ER/Outpatien	IL 3 DOA	Other: 4 Nursing Ho		e) ance 6 □Other (Spe ow injury occurred	→cify)
vision	or Attanding Phater death. Diractor: After thin by the funeral	Certification;	Sample Sample	28e. Place of tnjury - A	at home, farm, str	M 1	jury at Vork? □ Yes 2 □ No	28f. Location (St.	reet and Number or R	tural Route Number.
Ö	To the Host ital or Al within 24 hours after of To the Funeral Dirac completely illed in by	sal Cert	29a. Certifier in Certifying Phys	building, etc. (Spe	knowledge death	occurred at the	time, date and place,	City or Town	n, State)	
	To the Host ital within 24 hours a To the Funeral Completely illed	Medical	(Check only 2 Medical Examile one) 29b. Signature and title of certifier	ner: On the basis of exam and manner stated.	ination and/or inv	estigation, in m	y opinion, death occur	red at the time, da	ate and place, and due 9d. Date signed (Mont	e to the cause(s)
	1/		Name and address of person who so	mpleted cause of death (It	tem 23a) (T	Print)	55034	, , , ,	4-20-	-06
,	Stat Registra		31. Date filed (Month, Day, Year) ADR 2. 1. 2006	32. Registrar's Sig	nature		remit of the	phila or	IVE DU	10., NO 2125

06-02610 Kayah Jackson

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 12515

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ACUTY TO LOCATION DOWN Discovery Hospital University Hospital Univ	Physicia	an/	Decedent's Name (First, Middle	,Last)					2				ime of Death
University Hospital Director	tical Exami	ner	KAVAH	A		. 77	ACKS	ON		April 17, 2	006 Year	1	1126 hrs
Since Score have where the service of the service o			4a. Facility Name (if not institution	, give street and num	ber)	4	b. City, Town,	or Location				f Death	
The color of the c			University Hospital									11/1	
The color of the c	Euporol		5 Social Security Number 6	Sex 7	Age (In vrs. I:	ast hirthday)	If Under 1 V	ear If Unc	for 24Hrs	8 Date of Birt	h (MM/DD/VVVV)	9 Ridhala	oo (State or
Total Disease Total Diseas					. rigo (iii yio. ii	act birtingay)				o. Date of Birt	(IVIIVIIDD/FTFF)	Foreign	
The country of the co	Director		211-71-9381	1 M 2 X F		Yrs.	2	,		JAN. 3	31,2005	Country	MARYLANI
The control of the			Usual Residence of Decedent								1		7
The composition of the place of	any		10a. State 10b. County		10c. City,	Town or Location	on				_	10d	Inside City Limits
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The composition of the place of	leath ite	١	1 Never Married 2 Mar	IICU		If Ye	es, specify Cut	oan, Mexicai	n, Puerto R	ican, etc.)	White,	etc.	
The composition of the place of	ier c	Ē	3 Widowed 4 Divo	rced If Yes, Give Year	- 23 110	1	Yes 2 X	No specify	<i>r</i> :		Specify:	RI.	ARV
The composition of the place of	urs a	<u>v</u> .	15. Decedent's Education (Speci		completed)					rk done			1 -
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The composition of the place of	d Me d Me	ို	19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailing	Address (St	reet and Nu	mber or Ru	ral Route Num	ber, City or Town	, State, Zip	Code)
The composition of the place of	S sh an b an 27 i		SHAKIA VOUL	NG (MO	THER	1163	31/	NCE	NT	CT. 6	BALTO,	MD.	21217
Physician Medical Naminer 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory/shrrest, snock, or heart approximate instead setting in clearly later to the cause or each line. 25a Part I. Enter the disease, or conditions, immediate caused the death. Do not enter the mode of dying, such as cardiac or respiratory/shrrest, snock, or heart approximate instead setting in clearly later to mediate a set of minimal setting in clearly later to mediate a set of minimal setting in clearly later to mediate a set of minimal setting in clearly later to mediate a set of minimal setting in clearly later to mediate set or injury that initialised events resulting in death). Late to cross a consequence of: 25a Part I. Enter the disease, or conditions, and Multiple Injuries Due to (or as a consequence of): 25a Universal part of the conditions of the co	and and lealt transfer		20a. Method of Disposition		20b. F	Place of Disposit	tion (Name of			Date	20c. Location - 0	City or Towr	n, State
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Paysician Madical Xaminor 23a Part L Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory/arrest, snock, or heart failure. List not only one cause on each line.	© ≅ ĕ ĕ Ē [I WAN I) (() Y	W)	125	1460	FUL	LTON	AVE.	BAITO.	MA	21217
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ORIGINAL

Physicia		1. Decedent's Name (First, Middle Catherine	, Last)	Jones					2. Date of Dea Month	Day	2006	3. Time of Deal 7:45
/Medic Examin		4a. Facility Name (If not institution,	give street and n		4b. City,	Town, or L	ocation of	Death			ounty of Deeth	, , , , , , , , , , , , , , , , , , , ,
,		Johns Hopkins		nter	hday) If Under	(timor	If Under 2	ATY	8. Date of Birth		O Birth	place (State or For
Funeral Director		5. Sociat Security Number 213–28–3611	6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs. last birt.	rs. Months	Days	Hours	Min.	(Month, Day Aug 20,	, Year)	Cou	ntry)
*		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location							10d. Inside City Lir
ital Hygiene. Id other than "natural", or items 23e or 28a-f show svant, the Medical Exantrae must be notified at	Į.	MD		Rali	imore							1 ½ Yes 2 □
r 28a	Funeral Director	10e. Street and Number		Dari	10f. Zip	Code				10g. Citize	on of What Cou	ntry?
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tems er m	uner	11. Marital Status	Armed F		13. Was Dece If Yes, spe	dent of Hisp cify Cuban,	panic Orig Mexican,	in? (Spe	cify Yes or No- Rican, etc.)	14	Btack, White,	
r. or	by F	1 Never Married 2 Marri 3 ⊠ Widowed 4 Divorced	od 1 Yes If Yes, C Year or	2 ⊠ No live Dates:	1 ☐ Yes	2 🛛 No	Specify:			s	Specify: Whit	- 0
atura cal E	ted	15. Decedent	's Education	16a.	Decedent's Usu			må sammlei		16b. Kind	of Business/In	
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ed of	Be	17. Father's Name (First, Middle, I	Last)						(First, Middle,		umame)	
f Health and Mental item 27 is marked or other traumatic svs	၉	John Crispens 19a. Informant's Name/Relationsh	nip (Type, Print)	19b.	Mailing Address				Richte		Town, State, Zip	Code)
125		Johns Hopkins			05 Bayv							ŕ
if item if item or othe		20a. Method of Disposition		20b. Place of	Disposition (Na.	me of			ate		ation - City or To	own, State
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Department Important: If any injury or once.		21. Signal of Funeral Service I	S. Madd.	Affector	22. Name a State Baltin	Anato	my B	oard	655 W,	Bal	timore	Street
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ysician	8 1	Immediate Cause (Final disease or condition	. Du	monary	ambol	ws		-1	01		1	Onset and Dea
Medical caminer	Н	resulting in death)	ue to	o (or as e onsequente o	of):			//	//_			5 DAI
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ansit	Examiner	Cause (Disease or injury that initiated events						ION APPF	OVED BY			
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hysician and the burial-transit	Icai		d									
O 10	/Med	IF FEMALE:	220 H vas a	utcome of pregnancy								
attending for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Fetat death	3 ☐Ectopic p					23	d. Date of delive Month	ery Day Year
by the a	ysic	1 □ Yes 2 MNo 9 □ Unknown	9☐Unk		3 (Other (s)	Jecny)						
signed b	by Pr	Part II. Other significant condition	ons contributing to	death but not resulting in	the underlying	cause giver	in Part I.		23e. Did to	bacco us	e contribute to t	he cause of death
been sig should bi		COPU							1 🗆 Y	es 2 🗆	No 3 ☐ Prot	pably Unkr
has been je 2 shoul	Completed								24a. Was a		24b. Were auto	ppsy findings avai
ate ha	Com								perfor	med? 2 ☐ No	death?	2 No
certificate rector, pag	Be (25. Was case referred to medical examiner?	11			100		of Death	(Check only or	10)		
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After funer	tion	1 Statural 5 Pendin	a (Mo	nth, Day Yeer I	tury KNOWN	28c. Injury a Work?	9' es 2 1€ 7N		Subjec			
deau ctor: y the	Certification:	3 Suicide 6 Could r	not be 28e. Pla	ce of Injury - At home, far					28f. Location (S	treet and	Number or Run	al Route Number,
Direct of the by	erti	4 Homicide	Dul	ding, etc. (Specify)					39 Wi	n, State) I ndso	r Way.	mນ Rosedale
= =	Medical (29a. Certifier Certifyin (Check only one)	Examiner: On the	he best of my knowledge basis of examination and unner stated.	, death occurred d/or investigation	at the time n, in my opi	, date and nion, deat	d place, a	and due to the o	ause(s) a	nd manner as s	tated.
24 hou Fune stely fil	ě	29b. Signature and title of certifier			29	c. License	number		2	29d. Date	signed (Month.	Dey, Year)
vit in 24 hou For the Fune completely fil	2											
with in 24 hours after death To the Funeral Director: completely filled in by the	2	* Lound	aVATIL	W		DE	388	549		4	108/0	06

			1 - For State Registrar	State of Ma	aryland / [epa <i>Cer</i>	rtment	of He	ealth a Death	ınd M	ental H	ygiene Reg. No.	200	6	1251	1
I	Physici /Medic		1. Decedent's Name (First, Middle, Last) Catherine		Jaku	bi	1				2. Date of D Month April	Day	200		3. Time of Deat	th M
	Examir		4a. Facility Name (If not institution, give state) The John's Hopkins 5. Social Security Number 6. Sex	Hospita	(In yrs. last birt	hdayl		tim	ocation of	C1+>	/ 0 Bara at B		County of D			
	Funeral Director			M 2 F		Yrs.	Months	Days	Hours	Min.	8. Date of B (Month, L June	av. Year)		Count	ace (State or Form) Land	өідп
	ith the Maryland or 28a-f ehow	Director	10a. State 10b. County MD 10e. Street and Number		10c. City, Town		10f. Zip	Code				10g. Citiz	en of What		d. fnside City Lin 12 Yes 2 Ty?	
0036	be filed within 72 hours after deeth with the Maryland ital Hyglene. d other than "natural", or items 23e or 28e-f ehow event, it a Medical Exercilier must be notified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 XX If Yes, Give Year or Dates:	lo	1	Vas Decede Yes, spec □ Yes 2	No	Specify:	jin? (Spe Puerto f	city Yes or N Rican, etc.)		4. Race - A Black, V		tc.	
Maryland 21215-0036	I within 72 I lene. r then "nat	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 9th	cation completed) College (1-4or 5	+)	(Give I life. E	ent's Usual kind of word OO NOT use emake:	k doné du e retired)	ion ring most	of workir	ng		d of Busine		ustry	
/land		To Be C	17. Father's Name (First, Middle, Last) James Swan		<u>_</u>	TOINE	зшаке.	1			(First, Middle	e, Maiden S	n hon Gurname)	1e		
	s 1 and 2 should I Health and Mer Item 27 ie marke other traumatic		19a. Informant's Name/Relationship (Type John Jakubik / Son		90)15	Moons	stone		d, B	Route Numi altimo			e, Zip (
Baltimore,	Page nent o ant: If ary or		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		20b. Place of cometers Metro	v, crem Cr	atory or oti :em .	her place)	0	4-20	-06	Balti	more,	MD		
a n	permit. Departimontal		21. Signature of Funeral Service Licenses	vexex	the death. Dea	02	224 Ea	ıster	n Ave	e.,	Baltim	ore.	1er &	<u> 122</u>	·	
>	Physician /Medical		23a. Part1 Enter the disease, or complies shock, of heert failure. List only on firmediate Cause (Final disease or condition resulting in death)	Hypote	MSION		r the mode	or dying,	such as c	ardiac or	respiratory	arrest,		1	Approximate nterval Between Donset and Death	
9/00,	death certificate be executed xx eattending physicien and mid for use as the burial-transit	dical Examiner	Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Sepsis Direct (2000)	consequence of conseq	n):									day	
O. Box of	ath certifi attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	Sc. If yes, outcome of 1 Live birth 34 Pregnant at 9 Unknown	2 ☐ Fetaf death		Ectopic pre Oth <i>e</i> r (s <i>pe</i>					23	d. Date of Month	-	ay Year	
cords, P	w requires thet the de been signed by the should be detached	۵	Part II. Other significant conditions con	ributing to death bu	t not resulting in	the un-	derlying car	use given	in Part I.		İ	tobacco use			cause of death?	
al neco	: The law re cate hes bee	Completed									24a. Was auto perfe 1 Yes		24b. Were prior death 1 Y	o comp	y findings availal oletion of cause o	ble of
ion or vital	To the Hospital or Attending Physician: The law within 24 burus after deads. To the Funeral Director: Atten this certificate hes completely filled in by the funeral director, page 2.	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	ospital: 1 Inpatier 28a. Date of Injun (Month, Day	28b. Ti			Other: c. Injury a Work?	4 🗆 Nurs	sing Hom	(Check only e 5 Res 3d. Describe	idenc <i>e</i> 6 l		pecify)		
DIVIS	ital or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc.	ry - At home, farm (Specify)	n, stre	et, factory,	office		28	3f. Location (City or To	Street and wn, State)	Number or	Rural F	Route Number,	
	thin 24 hos the Fune mpletely fil	Medical	29a. Certifier (Check only one) 1 ★ Certifying Phys. 2 ★ Medical Examin 29b. Signature and title of certifier	cian: To the best of er: On the basis of and manner stat	examination and	death /or inve	estigation, i	n my opin	ion, death	place, ar occurre	nd due to the d at the time,	date and p	ace, and c	ue to th	ne cause(s)	
-			>~~/	Medical			4	License n	- <i>0</i> 0(0		Aprı	signed (Mo			
) Sta		30. Name and address of person who cor Michael Fradley The 31. Date filed (Month, Day, Year)	Johns Hop	kins Hos	pita	1,60	0 Nor	th Wo	olfe S	treet,	Baltim	orc, Ma	rylo	ind 2128	37
	Sta Registra		APR 2 1 200	6	- Signature	And										

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#7,8,per#H 855 5/1/2006 TT Department of Health and Mental Hygiene 0 0 5 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death Physician Month' 1236 M 4prul ONNa ZOXO /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner **GBMC** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1961

7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1961

7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 0.5 - 1.8 - 1.961 Baltimore 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F 213-70-2223 **Director** Maryland Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow if of Health and Menial Hygiene.
If Item 27 is marked other then "naturel", or Items 23s or 28s-1 show or other treumstic event, I'm Medical Example annual be notified at 1 No 2 No Funeral Director MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4100 Belvieu Avenue 21215 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Maryland 21215-0036 African-American 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11th Housekepper Nursing Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked othe eny linjury or other treumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Crowder Eugenia Maddox 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1730 Hartsdale Rd., Balto.MD 21239

ace of Disposition (Name of Date 20c. Location - City or Town, State Dolores Crowder/Sister Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1) Qurial 2 ☐ Cremation 3 ☐ Removal from State 4/22/06 Lansdowne, MD 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion 22. Name and Address of Facility Wylie F/H
200 Liberty Rd., Randal
234 Part. Enter the disease, or complications that redused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death)

a. Cerebrouse 22. Name and Address of Facility Wylie F/H PA of Balto. Co. 9200 Liberty Rd., Randallstown, MD 21133 Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗍 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗹 No ဥ this After thi 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 ☑Natural 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funaral Director: At completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number mia - 0 Kin 4/20/06 031865 P, mo 30. Name and address of person who completed caus of death (Item 23a) (Type, Print) Baltimore 82 N. Entan street 206 32 distrar's Signature. 31. Date filed (Month, Day, Year) State APR 2 1 2006 Registrar

Christopher Dorsey Landes

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 125	I C	
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		Registrar			Certit	ficate of	Death			Re	eg. No.	100	10 1231
Physici Medical Exami		Christopher Dorsey Landes								Date of Deat Month April 15, 2	Day	Year	3. Time of Death 1140 hrs
		4a. Facility Name (if not instituti Memorial Hospital		umber)		4	b. City, Town, o Cumberlai		of Death			ounty of D gany	reath
Funeral Director		5. Social Security Number 214-44-8306	6. Sex	7. Age (1 58	In yrs. last	birthday) Yrs.	If Under 1 Ye Months Da			8. Date of Birt	•		9. Birthplace (State or oreign Country) Md
Maryland 28a-f show any 1 at once.	tor	Usual Residence of Decedent 10a. State		10	* .	wn or Location							10d. Inside City Limits 1 Yes 2 X No
h the Mar 3a or 28a otified at	Director	RR1 Box 245					10f. Zip Code 267.	53		10	og. Citizen US		Country?
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. unt: If item 27 is marked other than "natural", or items 23a or 28a-f shour other traumatic event, the Medical Examiner must be notified at once.	by Funeral		12. Was De Armed F 1 Yes vorced If Yes, Give Ye or Dates:	orces? 2 X	No	If Ye	Decedent of H s, specify Cuba Yes 2 X N s Usual Occup	o specify	n, Puerto Ri	can, etc.)	Spe	White, et	merican Indian, Black, tc. hite ess/Industry
1036 vithin 72 hou ene. or than "nat Medical Exa	Completed	Elementary/Secondary (0-12)	College (1–4 or 5+)			st of working lif					rt	ssandustry
21215-0036 build be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	17. Father's Name (First, Middle Theodore Lan	des			-		Mary	y Thon	1			
e, MD 21 1 and 2 should Health and Me item 27 is man	<u>۲</u>	19a. Informant's Name/Relation Richard Landes			- 1	857 Re	gent St	., We	estmin	nster,	Md 23	1157	State, Zip Code)
		20a. Method of Disposition 1 Burial 2 X Crematio 4 Donation 5 Other S	pecify:	om State	cren	natory or othe County	Cremat	ion	4-20-		Sykes	svill	y or Town, State Le,Md
		21. Signature of Funeral Service	get ofer			Ρ.	O. Box	195	Sykes	sville,	Md 2	21784	& Chapel
Physician /Medical xaminer		23a. Part I Enter the disease, o failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	e on each line.	ed acı	ite my		e mode of dying		cardiac or re	espiratory arre	est, shock,	or heart	Approximate Interval Between Onset and Death
·	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b. Atheros Due to (or as a	clerot	tic car	rdiovasc	cular dis	ease					
uted Id ransit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequ	ence of):								
3760, ficate be executed g physician and s the burial - transit	an/Medical	X UNPENDED					ME,G854,	4/27/0	6 TT				
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transi	Physician/N	23b. Was decedent pregnant in t past 12 months? 1 Yes 2 No 9 Un	4 Pregr	oirth nant at tim	of pregnan	2 Feta	il death 3 er (Specify)	Ectopio	c pregnancy	′	23d. Da	ate of deli	very Day Year
s, P.O. uires that the n signed by d be detached	δ	Part II. Other significant condi	tions contributing to	death bu	ut not resul	ting in the un	derlying cause	given in Pa	art I.	23e. Did tob			e to the cause of death? Probably 4 Unknown
Division of Vital Records, Isl or Attending Physician: The law requir rs after death. al Director: After this certificate has been sted in by the funeral director, page 2 should the fine of the page 2 should the funeral director.	Completed									24a. Was a autops perform 1 Yes 2	ned?	24b. Were prior death	
Vital I ysician: his certifi director,	o Be (25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital:	npatient	2 🗸 ER	/Outpatient		of Death Other	(Check only		Residence	6 0	ther:
ion of Vital F tending Physician: eath. ior: After this certifi the funeral director,	\vdash	27. Manner of Death 1 X Natural 5 Pen		of Injury , Day,Year)	28	b. Time of Inj	´ `	ury at Work	? 28	d. Describe ho			
ie so	Certification:	3 Suicide 6 Cou		e of Injury	- At home	, farm, street,	factory, office	building, et	c. 28	f. Location (St or Town, Sta		lumber or	Rural Route Number, City
To the Hospital within 24 hours a To the Funeral completely filled	edical	one) 2 Medical Exa	hysician: To the best miner: On the basis and manner s	of examina	nowledge, o ation and/o	death occurre or investigatio	n, in my opinio	n, death oc	ace, and due curred at th	e time, date a	nd place, a	and due to	o the cause(s)
net		29b. Signature and title of certific	n. D				29c. Licen	se number M.E.			29d Date April 20		Month, Day,Year)
J. C			int Medical Exar				Baltimore,	MD 212	01				
St Regist	ate rar	31. Date filed (Month) 2007	1 2006 32. Re	ristrar's S	Signature	Age	well .						-
			-										

				1 - State of Maryland State of Maryland		rtment of Heatificate of De			jiene	6	12520
	40			Decedent's Name (First, Middle, Last)				2. Date of Dea	th		3. Time of Death
_		Physici		Catherine S. Lee				April	16, 200	6 Yeer	0445 M
	1	/Medic Examir		4a. Fecility Name (If not institution, give street and number)		4b. City, Town, or Lo	ocation of Death		4c. County		
				Upper Chesapeake Medical Center		Bel Air	2		На	rfor	i
		Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 220-20-1646 1 M 2 F 76	t birthday) Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Feb. 4,	. Year)	Cou	place (State or Foreign ntry) y Land
		D s		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Loc	cation					10d. Inside City Limits
		eho eho	ö								1 ☐ Yes 2 ☐ No
~		he M	Director	Md. Harford 10e. Street and Number		Bel Air			l 0g. Citizen of V	A/bas Carr	25
2		with	늅	502 East Wheel Road			1015		U.S		nuty?
7		eath	era	11. Marital Status 12. Was Decedent Ever in U.S.	13 V			acify Yes or No.			can Indian,
1 5440	36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Evant on must be notified at once.	by Funeral	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:		Vas Decedent of Hispa Yes, specify Cuban, I ☐ Yes 2 No 5	Mexican, Puerto Specify:	Rican, etc.)	Specify	ck, White,	
7	Ö	2 hou	ed	15. Decedent's Education	16a. Deced	ent's Usual Occupatio	on	-	16b. Kind of Br	usiness/Ir	dustry
7	15	an 72	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give I	kind of work done duri OO NOT use retired)	ing most of worki	ng			,
0	212	d wit	E	12 years	dat	a clerk			insur	ance	
	Þ	othe othe	Bec	17. Father's Name (First, Middle, Last)		18	3. Mother's Name	(First, Middle,	Maiden Suman	10)	
	Maryland 21215-0036	hould bid Ments	To	Christopher Kammerer 19a. Informant's Name/Relationship (Type, Print)	19b Mailin	g Address (Street and		et Strol		State 7	Code)
		and 2 s eaith an n 27 ie		Kathy Jankowiak/daughter	502	East Wheel	L Road,	Bel Air	, Md. 2	1015	
4/16/06	Baltimore,	Pages 1 nent of H int: if iter		1 Burial 2 Cremation 3 Bemoval from State	ietery, crem	sition (Name of eatory or other place) rematory	j	/2006	20c. Location - Baltime		
9	alti	permit. Deperting Imports any injugance.		21. Signature of Funeral Service Licensee		Name and Address of					
7	m	80 E E 8		MUMM		chimunek F					
7				23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not ente	or the mode of dying, s	such as cardiac o	r respiratory arr	est,	d. 4:	A proximate Interval Between
	1	Physician		Immediate Cause (Final disease or condition	,1mo	nary E	Edeme	4		1	Onset and Death
		/Medical		resulting in death) Due to (or as a consequent							
		Examiner		Sequentially list conditions, b.							
		p #	iner	any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ice of).						
0		icate be executed physician and s the burial-transit	Examiner	that initiated events							
148	90	e executan a		Due to (or as a consequent	nce of):						
00	8760	hysic	dlcal	d						-	
0	9	entific ling p		IF FEMALE:							
986	D. Box	res that the death certificate be execu igned by the ettending physician and be detached for use as the burtal-tran	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1	eath 3 🗆	Ectopic pregnancy Other (specify)	*		23d. Dat Mo	e of deliv	ery Day Year
,	Ρ.	that the ed by detacl	P	Part II. Other significant conditions contributing to death but not resulti	no in the un	derlying cause gwen i	in Part I	23e Did to	hacco use cont	ribute to t	he cause of death?
J	ords,	The law requires that the tte has been signed by the bage 2 should be detache	ted by	End Stage Kidney L	rsea	SC -	iii raiti.		es 2 No	3 Prot	
4	Record	he law r e has be ige 2 sh	Completed	Diabetes Mellitus.				24a. Was a autops perform	med2	death?	opsy findings available impletion of cause of
	Vital	ilcian: Th certificate rector, pag		25. Was case referred to medical			C Discount Death	1 Yes	-	Yes	2 □ No
a)	Ē	Physician: this certific ral director,	o Be	examiner? 1 Yes 2 No Hospital: 1 Hospital: 2 EF	2/Outpationt		 Place of Death Mursing Hor 			/0	LA
4	of	Phys ar this aral di	To	27. Manner of Death 28a. Date of Injury 28	Bb. Time of	28c. Injury at Work?	4 Nursing Hor	28d. Describe h			y)
\leq	O	Attending I r death. octor: After by the funer	ij	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	Injury		2 No				
(Division	Attendir death.	fica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home	e, farm, stre	et, factory, office		28f. Location (S	treet and Numb	er or Run	al Route Number,
2	Ö	oital or urs afte real Dir lled in I	Certification;	building, etc. (Specify)			-	City or Tow	,		
Cat		To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the time, estigation, in my opinion	date and place, a on, death occurre	and due to the c ed at the time, d	ause(s) and ma ate and place,	nner as s and due to	tated. the cause(s)
		To To T	Σ	29b. Signature and title of certifier		29c. License no	umber	2	9d. Date signed	(Month,	Day, Year)
		de				و لا	>> 012		Apr	/ /	6/2000
		ie "		30. Name and address of person who impleted cause of death (Item 2) J. Keven Cymit ms.		2 Nor	th Av	e . 6	RelAI	>, -	nd-21014
	1	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signatur	· Sp	ente					

06-02300		
Lankford, Hunter		1- For State
Physicia Medical Exami	an/ ner	Registrar 1. Decedent's Name (First, Name) 4a. Facility Name (if not institution)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Franklin Square Ho 5. Social Security Number 218-73-9085 Usual Residence of Deceder 10a. State 10b. Cou 10e. Street and Number 1 Marital Status 1 Never Married 2 3 Widowed 4 15. Decedent's Education (Elementary/Secondary (0- N/A 17. Father's Name (First, Mic 19a Informant's Name/Relati 20a Method of Disposition 1 Neural 2 Crema 4 Donation 5 Othe 21. Signature of Funeral Servans Jacquelyn Evans

Please Type or Print in Black Indelible Ink

	State of Maryland	Department of He		Hygiene	2006	12521
_	Registrar	Certificate of Dea	ain	Reg. I		12021
ın/ ner	1. Decedent's Name (First, Middle,Last)	ny ford		2. Date of Death Month Da	y Year	3. Time of Death 7:03 pm
	4a. Facility Name (if not institution, give street and number)	4b. City	, Town, or Location of Dea	April 3, 2006	4c. County of Death	1.00 P111
	Franklin Square Hospital		sedale		Baltin	Dre
	5. Social Security Number 6. Sex 7. Age	e (In yrs. last birthday)	nder 1 Year If Under 24H	rs. 8. Date of Birth (N		place (State or Foreign
	218-73-9085 1VM 2 F	Yrs. Mo	nths Days Hours M		2005 mc	-4
	Usual Residence of Decedent		0 1	10-21	2000 1110	irgiuna
	10a. State 10b. County	10c. City, Town or Location				10d Inside City Limits
ե	MD Baltimore	Parkville				1 Yes 2 No
ectc	10e. Street and Number	10f. 2	Zip Code	10g	Citizen of What Count	ry?
ä	7806 OID Harford Ro	١.	21234		USA	
Funeral Director	11. Marital Status 12. Was Decedent		dent of Hispanic Origin? (14. Race - Americ	an Indian, Black,
ň	1 Never Married 2 Married Armed Forces? 1 Yes 2		ecify Cuban, Mexican, Puerl	to Rican, etc.)	White, etc.	110
by F	Widowed 4 Divorced of Pear or Dates:	1 Yes	2 No specify:		Specify: Wh	ite
eq	15. Decedent's Education (Specify only highest grade com	during	al Occupation (Give kind of	work done 16	b. Kind of Business/In	dustry
Completed by	Elementary/Secondary (0-12) College (1-4 or 5	most of working	g life. DO NOT use retired)		NIA	
E	17. Father's Name (First, Middle, Last)	/	18 Mother's Nam	ne (First, Middle, Maid	lon Surnama)	
BeC	Tames Willeton I as	nx ford	Kimb	erly M	chelle	Kayamah
T0 B	19a Informant's Name/Relationship (Type, Print)	19b. Mailing Addre	ess (Street and Number or	Rural Route Number	City or Town, State.	Zip Code)
	James W. Lankford	7001 0	ld Harford	101 m.	-KVIIIE M	1) 21234
	20a Method of Disposition	20b. Place of Disposition (N	lame of cemetery,		c. Location - City or T	own, State
	1 VBurial 2 Cremation 3 Removal from Sta	PORY LOCOCI (encetra 41	7/0/2 1	Parkaille	10 - A
	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	I WI KWOOL (nd Address of Facility	100	a kome	mp .
	Jacquelyn Evans MO1448 (per DVR)	8800	Harton	s Hunera	i chepel	of Memories
	23a. Part I. Enter the disease, or complications that caused	the death. Do not enter the mod	e of dying, such as cardiac	or respiratory arrest,	shock, or helart	Approximate Interval
	failure. List only one cause on each line. Immediate Cause (Final disease a. Sudden unex	plained death in i	nfancv			Between Onset and Death
	or condition resulting in death) Due to (or as a conse					
Ļ	Sequentially list conditions, b.					
ine	if any, leading to immediate Due to (or as a consecute Cause. Enter Underlying Cause	equence or):				
Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a conse	equence of):				
	d.	Was an an an				
edical	X UNPENDED X AMENDED it	em#21,23a,27,28a-f	,perFH,ME,g856,6	5/28/06 TT		
Š	IF FEMALE: 23b. Was decedent pregnant in the 1 Live birth		th 3 Ectopic pregr		23d. Date of delivery	Vees
ciai	past 12 months?	time of death 5 Other (S		iancy	Month Da	ay Year
Physician/M	1 Yes 2 No 9 Unknown 9 Unknown		**			
ج ۳	Part II. Other significant conditions contributing to death	but not resulting in the underly	ing cause given in Part I.	_	co use contribute to th	
Completed by				1 Yes 2	No 3 Proba	bly 4 Unknown
Set				24a Was an autopsy		psy findings available mpletion of cause of
mo				performed 1 ✓ Yes 2	l? death? No 1 ✓ Yes	2 No
Bec	25. Was case referred to medical		26.Place of Death (Check	k only one)		
To B	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatie	nt 2 ER/Outpatient 3	DOA Other Nurs	ing Home 5 Res	idence 6 Other	
ï.	27. Manner of Death 28a. Date of Inju (Month, Day,Y.	ry 28b. Time of Injury	28c. Injury at Work?	28d. Describe how	injury occurred	
atic	Natural 5 Pending Investigation unk	unk	1 Yes 2 No	unk		
tific	3 Suicide 6 X Could not be 28e. Place of Inj	ury - At home, farm, street, factor	ery, office building, etc.	28f. Location (Stree	et and Number or Rura	Route Number, City
Ser	4 Homicide determined (Specify) unk			unk		
Medical Certification:	29a. Certifier 1 Certifying Physician: To the best of my one) Medical Examiner: On the basis of examiner					
T edi	and manner stated.					
2	29b Signature and title of certifier	1	29c. License number		d. Date signed (Mont	h, Day, Year)
	() while		O.C.M.E.	A	pril 4, 2006	
	30. Name and address of person who completed cause of de	eath (Item 23a)				

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Laron Locke MD. State Registrar

Assistant Medical Examiner

32. Regitrar's Signature ORIGINAL

111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 OCME 10/2003

Physician /Medical Examiner

06-02561

Please Type or Print in Black Indelible Ink

eith Moore		State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. 2065	252
Physiciar ledical Examin	1/	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year	
and the second		4a. Facility Name (if not institution, give street and number) Good Samaritan Hospital 4b. City, Town, or Location of Death Baltimore City	
Funeral Director	5	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 6. Birthplace (State 20 - 86 - 4045 1 1 1 4 3 Yrs. Months Days Hours Min. March 1,1963 Country) N	ite or
Aaryland 28a-f show any Latonce.		$M_{\rm d}$	e City Limits
ith the Maryl 23a or 28a-1 notified at	호 호		
fter death wit 1", or items 2 ier must be in	Lune	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Yes, Sive Year 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, White, etc.	Black,
hour hour	pleted by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	Ita
21215-0036 Uld be filed within 7. Mental Hygiene marked other than c event. the Medical	8 Re	Harold Moore Annette Harris	110.
— P = E #	<u></u>	Mrs. Annette Moore 3129 Mondaymin Ave. Balto, Md. c 20a Method of Disposition (Name of cemetery, Date 20c. Location - City or Town, State	21216
.도 ~ 원 등 능 .	1	1 X Burial 2 Cremation 3 Removal from State Arbutus Mem. PK. 4/34/3006 Balto, Mo 21. A nature of Funeral Sefvice Licenses	d.
Balti Balti Departu Import injury e	4	23a. Art I. Enter thy disease, or complications that comed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximately 1975 Approximately 1975	nate Interval
/Medical Examiner			Onset and leath
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	
uted d ansit	Examiner	0	
760, cate be execut physician and he burial - tra	Medical	X UNPENDED AMENDED item#23a,27,28a-f,perME,g855,5/1/06 TT IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	
ox 68 eath certification for use as t	sician/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)	Year
ires that the d	2	1 Yes 2 No 3 Probably 4	f death? Unknown
Division of Vital Records, tal or Attending Physician: The law requirers after death al Director: After this certificate has been seled in by the funeral director, page 2 should be a be a bar and	Completed	24a. Was an autopsy finding autopsy prior to completion of death? 1 ✓ Yes 2 No 1 ✓ Yes 2	
Vital Reorysician: The	e l	25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 4 Jeasture 10 FD(Outsetiers 2 DOA Other, Death Doal Other, Death Deat	
ion of tending Pheath	tion: T	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending Production 1 Yes 2 X No Vink 28d. Describe how injury occurred 1 Yes 2 X No Vink 28d. Describe how injury occurred 1 Yes 2 X No Vink 28d. Describe how injury occurred 1 Yes 2 X No Vink 28d. Describe how injury occurred 28d.	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	Accident Investigation 3 Suicide 6 X Could not be 4 Homicide Homicide Investigation 5 Found: Residence Injury - At home, farm, street, factory, office building, etc of Town, State) 1813 Swansea Roam Baltimore, MD	umber, City
To the Hospital within 24 hours To the Funeral completely filled	Medical		
	Š	Mayorte Meisbell O.C.M.E. April 16, 2006	ar)
		30. Name and a dress of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Sta Registr	w		
DHMH 17 Rev 1/200	01	ORIGINAL	

			1 - For State Registrar	State of	Marylan		artment tificate			and Men		ene	6	1252	3
	Physici	an	1. Decedent's Name (First, Middle, Las Nelson L. Mensch	st)	·						Date of Death		 2	3. Time of Dea	ath M
	/Medic Examir		4a. Facility Name (If not institution, given 1777 Simms La	street and num	ber)			Town, or .over	Location of		ZIPI I	4c. County Anne	of Death		
	Funeral Director		210 20 2130	9x 7	. Age (In yrs. 7	8 Yrs.	If Under Months	1 Year Days	If Under		Date of Birth Month Day, ne 3,	Ĭ927	9. Birthp Coun	lace (State or Fo try) MD	reign
	e Maryland 3a-f show diffed at	ctor	Usual Residence of Decedent 10a. State 10b. County MD Anne Aru	ndel		y, Town or Lo lanover	cation						1	0d. Inside City L	
	h with th	al Dire	10e. Street and Number 1777 Simms La				10f. Zip	076			10	g. Citizen of V US		try?	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, Ite Modical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1% Yes 2 If Yes, Give Year or Dat	es? ! 🗌 No		Vas Decedi Yes, spec			gin? (Specify I, Puerto Rica	Yes or No- n, etc.)		e - Americ k, White,	etc.	
Baltimore, Maryland 21215-0036	d within 72 hogiene. sr than "natu	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucation de <i>completed)</i> College (1-	4or 5+)	life. L	lent's Usua kind of won DO NOT us V Rep	k done di e retired)	uring most	t of working	16	6b. Kind of Bu	siness/Inc	dustry	
land	uld be file fental Hy, rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last) Albert C. Mensch							ir's Name <i>(Fir</i> Lum Ble		aiden Sumam	Θ)		
Mary	nd 2 shou alth and M 27 is ma		19a. Informant's Name/Relationship (7 John L. Mensch	ype, Print)		19b. Mailin 1435	g Address Oden	(Street a	Rd, C	or or Rural Ro Oden tot	ute Number, 0	City or Town, 21113	State, Zip	Code)	
more,	Pages 1 a ent of Hes nt: If Item ry or othe		20a. Method of Disposition 1 □ 38urial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		tate C	Place of Disposemetery, crem	natory or oti	her place	· 1	Date 421-06		oc. Location -			
	Pnysician /Medical Examiner	Examiner	21. Signatu Funeral Service Liston Cregory Fin 23a. Part 1. Enter the dheaks, oncome shock, or heart failure. List only Immediate Cabse (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	olications that can one cause on ear	01148 used the death th line.	n. Do not ente	25 Cr. er the mode	ain of dying	Hwy S	cardiac or res	ı Burni	it,	210	6 1 Approximate Interval Betwee Onset and Deat	
8760,	icate be executed physician and s the burial-transit	dical	resulting in death) Last		r as a consequ		Market 1	-	DE	CHSY	V				
.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		h 2 ∏ Fetal nt at time of de	death 3	Ectopic pre Other (spe					23d. Date Mon	e of deliver	ry Day Year	
S, G	w requires that been signed b should be deta	by	Part II. Other significant conditions of	ontributing to dea	th but not resu	ulting in the un	derlying ca	use giver	n in Part I.			_	ibute to the	e cause of death	
II Record		Completed	- Dejenser Tiva	7000.	9 4	isem	<i>510</i>				24a. Was an autopsy performe I Yes 2	id? pi	Vere autoprior to comeath?	sy findings avail apletion of cause 2 No	able of
Division of Vital	Attending Physiclan: The r death. ector: After this certificate hiby the funeral director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Ceath 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 lnp 28a. Date of (Month,		ER/Outpatient 28b. Time of Injury		Other c. Injury Work?	4 □ Nur	sing Home	-	ce 6 □Othe)	
Divis	afte Dir	Certification:	3 Suicide 6 Could not be 4 Homicide determined	280. Place o	f Injury - At ho	me, farm, stre	et, factory,	office			ocation (Streetity or Town, S		or or Rural	Route Number,	
	To the Hospital or Attending Ph Within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	vsician: To the b iner: On the bas and manne	is of examinati	wledge, death ion and/or inv	occurred a estigation, i	t the time	, date and nion, deat	d place, and d h occurred at	ue to the caus the time, date	se(s) and man a and place, a	nner as sta nd due to	ited. the cause(s)	
	To the within 2 complet	Ň	29b. Signature and title of certifier				29c.	License	number		29d	. Date signed	(Month, D	Day, Year)	
4	50		30. Name and address of per in who of	omply d ause	of death (Item	23a) (Type, F	Print)	20	80	7 9 m 9	5+	tli91 Ba	200	Md.	
	Sta Registra		31. Date filed (Month, Day, Year)	006	istrar's Signat	ture	edi)	`		<u> </u>					

		1 - For State Registrar	State of Marylan		artment of F rtificate of			Reg. No.	6	2524
Physicia /Medic		1. Decedent's Name (First, Middle, Last Helen Augus					2. Date of De	1 ⁹ 20	0 ^Y 6 ^{ar}	3. Time of Death
Examin		4a. Facility Name (If not institution, give 8620 Kelso Dri			4b. City, Town, o	r Location of Death	1	Balt	of Death imore)
Funeral Director			7. Age (In yrs. 89	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da May 2	6,1916	9. Birthpla Countr M1Ch	nce (State or Foreign nigan
Maryland s-f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Baltin		y, Town or Lo					100	d. Inside City Limits 1 ☐ Yes 2 X No
h with the 23a or 284	ai Director	10e. Street and Number 8620 Kelso Dri	.ve		10f. Zip Code 21 2 21			10g. Citizen of USA	What Countr	y?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatil and Mental Hygiene. Department of Heatil and Mental Hygiene. By injury or other traumatic event, the Madical Examerar must on citied an once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba ↑ Yes 2 No		pecify Yes or No o Rican, etc.)	Bla	ce - Americal ck, White, et y: Whit	tc.
within 72 ho iene. rthan "natui	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired SS Selec	during most of wor d)	rking	16b. Kind of B Libby Glass	- Owe	en
uld be filed lental Hyg rked othe	To Be C	17. Father's Name (First, Middle, Last) Alfred E. Hite	eshew			18. Mother's Nan Lyda	ne (First, Middle Lockha		ne)	-
and 2 shoualth and M		19a. Informant's Name/Relationship (7) Barbara Adams /			ng Address (Street Pox Ri		ne Balt	imore	MD	
Pages 1 announce of the sent: if item		20a. Method of Disposition 1 ☐ Burial 2 【▼Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State Ba	Place of Dispo cemetery, cre LYV1eW	osition (Name of matory or other plan of Cremat	cory 4-2	Date 1-2006	Balti		
permit. Departn importe any injt		21. Signature of Funeral-Service Licent	onnelly	C	2. Name and Addre	Funera		of Es	Balt sex 2	.o.MD !1221
Physician /Medical Examiner		23a. Part 1. Enter the disease of comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. ATHERO Due to (or as a conseq	SCL	EROT	ng, such as cardiac IC HE RTENS	ART	DISE/		Approximate Interval Between Onset and Death
vrequires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseq c. Due to (or as a conseq d							
he death certific the attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 (\$\frac{1}{2}\$No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3	□Ectopic pregnanc □ Other (specify) _	у			ate of deliver	y Day Year
uires that il	by	Part II. Other significant conditions of	ontributing to death but not res	sulting in the u	underlying cause giv	ven in Part I.		obacco use con Yes 2/10No		e cause of death?
The law requir tate has been si page 2 should	Completed						24a. Was auto perfo 1 Yes		Were autop prior to com death? 1 \(\sum \text{Yes} \) 2	sy findings available pletion of cause of 2 No
To the Hospitel or Attending Physicien: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending bompletely filled in by the funeral director, page 2 should be detached for use a	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		28b. Time of Injury	of 28c. Inju	her: 4 □ Nursing H ry at rk?] Yes 2 □ No			rred	
pltei or Al	I Certif	4 Homicide determined	28e. Place of Injury - At h building, etc. (Special special sp	fy)			City or To	wn, State)		
thin 24 hos the Fun the Fun empletely i	Medical		niner: On the basis of examina and manner stated.			opinion, death occu			and due to	the cause(s)
1 3 2 8		Jan Po	completed cause of death (Item	m 23a) (Type	D Print)	4000		4/3	0)	06
Sta	ite	JIM PARSHAL	~ 9105 F	RANK	LIN S	QUARE	DP.	BALT	MOR	E, MD
Regist	rar	APR Z 1	32. Renstrar's Sign	A A	greek!					

DHMH 17 Rev 1/2001

ORIGINAL

	•	1 - For S	ate of Marylan			of Hea		Mental Hy	giene Reg No	UUU	12525
Physic	an	Decedent's Name (First, Middle, Last) Margaret Mary Mc	Elroy					2. Date of De Month	Day		3. Time of Death
/Medi	cal	4a. Facility Name (If not institution, give stree			4b. City,	Town, or Loc	cation of Dea	April	19 4c.	2006 County of Deat	5:15a
Examit	ier	6001 Calvert Way			_	esvill				Carrol	
Funeral Director		5. Social Security Number 6. Sex 1 ☐ M	7. Age (In yrs. 81	last birthday) Yrs.	If Under Months		Under 24 Hr Hours Mir		rth ay, Year) 1925	9. Birth Co NY	oplace (State or Foreign untry)
land ow		Usual Residence of Decedent 10a. State 10b. County		y, Town or Lo							10d. Inside City Limits
Mary R-1 •h	ctor	Md Carroll	Sy	kesvil.	le						1 ☐ Yes 2 ☐ NO
h with the	Funeral Director	10e. Street and Number 6001 Calvert Way			10f. Zip	Code 21784				izen of What Co USA	untry?
be filed within 72 hours after death with the Maryland stal Hygiene. Indicates then "natural; or Items 23a or 28s-f show event, the Medical Examinar must be notified at	þ	1 Never Married 2 Married	Vas Decedent Ever in U Armed Forces? Yes 27 No f Yes, Give Year or Dates:		Was Deced f Yes, spec 1 ☐ Yes		anic Origin? Mexican, Pue Specify:	(Specify Yes or Norto Rican, etc.)	0-	14. Race - Ame Black, White Specify: Whi	e, etc.
vithin 72 horne. ne. hen "naturi	Completed	15. Decedent's Education (Specify only highest grade continuous) Elementary/Secondary (0-12)		(Give	dent's Usua kind of wor DO NOT us omemal		n ng most of w	rorking		ind of Business/ estic	Industry
filled v Hygie other t	a a	17. Father's Name (First, Middle, Last)		11.	Jinemai		I. Mother's N	ame (First, Middle			
uld be Vental Irked c	To B	Joseph Coyle				I	Emma S	ochor			
12 sho		19a. Informant's Name/Relationship (Type, Barbara Ferguson (da			-			Ru <i>ral Route N</i> um <i>t</i> kesville			Tip Code)
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other then enty injury or other traumatic event, IDE MADRE.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo	20b. F	Place of Dispo cemetery, crer orgetow	sition (Nam	ne of ther place)	= 1	Date NIA	20c. Lo	ocation - City or	
permit. Pa Departmen Important: ony injury		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	lau bas de	22	. Name an	d Address o	of Facility H	aight Fu	nera.	1 Home 8	
3 89E 9		23a. Part1. Enter the disease, or complicati	pound the deal					sville,		1784	Approximate
Physician /Medical Examiner	_	snock, or near failure. List only one of immediate Cause (Final disease or condition resulting in death)	Due to (or as a consec	nduence of):	1 F	1	1051			ľ	Interval Between Onset and Death
icate be executed physician and sthe burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Due to (or as a consec								
ath certification trending or use as	Physician/Medi	in the past 12 months? 1 \(\sum \text{Yes} 2 \) \(\text{No}\)	if yes, outcome of pregn 1□Live birth 2□Feta 4□Pregnant at time of a 9□Unknown	al death 3	Ectopic pr					23d. Date of dei Month	iv ery Day Year
luires that the devices that the device by the a	by	9 ☐ Unknown ▶ Part II. Other significant conditions contrib	uting to death but not res	sulting in the u	nderlying c	ause given i	in Part I.		tobacco		o the cause of death?
vical necolor sician: The law requir s certificate has been si lirector, page 2 should	Completed							24a. Wa auto peri 1 Yes	opsy formed?	prior to death?	utopsy findings available completion of cause of
Ital clan: ertifica ctor, p	BeC	25. Was case referred to medical examiner?					6. Place of D	eath (Check only			
Physic this or	မ	1 ☐ Yes 2 No	atal: 1 ☐ Inpatient 2 ☐ 8a. Date of Injury	ER/Outpatier			4 Nursing	Home 5 Res		6 ☐Other (Spe	cify)
Iding Piding Pith.	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	M	8c. Injury at Work? 1 ☐ Yes	s 2 No	200. 2030120	, 11011 1111	ny cocamou	
TO THE HOSPITAL OF ARTHURING Physician: The Within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ertification:	a □ Could not be □	8e. Place of Injury - At h building, etc. (Speci		reet, factory	, office			(Street arown, State		ural Route Number,
Hospita 24 hours Funera	edical C		an: To the best of my kn On the basis of examinand manner stated.								
To the	Me	29b. Signature and title of certifier	let, o	MD	290	License n	721	l	29d. Da	ate signed (Mont	h, Day, Year)
0		30. Name and address of person who comp Steven (Sillet,	leted cause of death (Ite	m 23a) (Type,	Print)	geto	ms	128.EU	der	sbuz	06 MD 2178/
St Regis	ate rar	31. Date filed (Month) Oay ; Year)	32. Reáistrar's Sign	ature	bert	7					
DHMH 17 Rev 1/	2001	WILL TO	- Jours	-/							

ORIGINAL

		1	For State Registrar	State of Maryland	l / Depa <i>Cer</i>	urtment of H	lealth a	nd Mental H	ygiene 006	12526
H	Physici		1. Decedent's Name (First, Middle, Last) Dawn Kimberly Me	elton-Alo				2. Date of Month	Death Day Year 16,200	
4	/Medic Examin	4	4a. Facility Name (If not institution, give stre Good Samarital	4		4b. City, Town, or Baitin	nore		4c. County of Dea	uth
	Funeral Director		5. Social Security Number 6. Sex 1 2 − 98 − 9287 1 0 N	7. Age (In yrs. Ia 35	st birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours			nthplace (State or Foreign ountry) MD
	aryland show	J.	Usual Residence of Decedent 10a. State 10b. County MD N/2		Town or Lo	cation imore				10d. Inside City Limits 1Ã Yes 2 ☐ No
	with the Manual a or 28a-f	Directo	10e. Street and Number 1233 Young Ct.			10f. Zip Code	21202		10g. Citizen of What C	ountry? USA
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show styling or other traumatic event, the Medical Examinant must be notified at ODGE.	y Funeral Director		Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2€ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 🙀 No	lispanic Orig an, Mexican, Specify:	in? (Specify Yes or Puerto Rican, etc.)	No- 14. Race - Am Black, Wh Specify:B1	ite, etc.
Maryland 21215-0036	within 72 hou ene. then "nature ne M. cirel E.	Completed by	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12) 12th	ompleted)	(Give life. l	dent's Usual Occup kind of work done DO NOT use retired al Heal	during most d)		16b. Kind of Business	ine Center
land 2	id be filed lental Hygi ked other ic event, I	To Be Co	17. Father's Name (First, Middle, Last) James Preston Me				18. Mother	's Name (First, Mide	dle, Maiden Surname) llen	
Mary	nd 2 shou alth and M 27 is mar r treumat		19a. Informant's Name/Relationship (Type La Verne Allen	, Print)	19b. Mailir 1233	ng Address (Street Young	an <i>d Number</i> Ct. B	or Rural Route Nur Saltimore	nber, City or Town, State, MD 21202	Zip Code)
Baltimore,	Pages 1 a nent of Hez nt: if item iry or othe		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Ren 4 □ Donation 5 □ Other (Specify)	CO CO	metery, crer	sition (Name of matory or other plan n Cemeto		Date 4/22/06	20c. Location - City o	
Balti	permit. Depertm Importa sny inju		21. Signature of Funeral Service Licensee	uj	5.	2. Name and Address	ss of Facility	Chatman-	-Harris Fu Baltimore	neral Home
	Physician /Medical Examiner		23a Part Enter the disease, or complication of the complete speech, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	tions that caused the death cause on each line. Since A Consequence of the cause o	ICH ence of):	er the mode of dyir	ng, such as c	cardiac or respirator	y arrest,	Approximate Interval Between Onset and Death
,8760,	icate be executed physicien end s the burial-transit	dicai Examiner	Sequentially list conditions, a say, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ						
.O. Box 6	ne death certifi the attending thed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3[Ectopic pregnanc Other (specify)	у		23d. Date of d Month	elivery Day Year
<u>a</u>	es tha	b	Part II. Other significant conditions contr	ibuting to death but not resu	Ilting in the u	nderlying cause gi	ven in Part I.		id tobacco use contribute ☐ Yes 2 ☐ No 3 ☐ F	to the cause of death? Probably 4 Donknown
I Records,	The law ate has b page 2 sl	Completed							utopsy prior to erformed? death?	autopsy findings available completion of cause of es DE No
Vital	Physicien: This certificatral director, p	Be	25. Was case referred to medical examiner?	spital:	R/Outpatie	Ott DOA OT	205	of Death (Check on	ly one) esidence 6 ⊡Other (Sp	and di
of	ding h. After fune	ition: To	1 Yes 2 No 27. Many r of Death 1 Natural 5 Pending 2 Accident Investigation		28b. Time o Injury	f 28c. Inju		28d. Descri	be how injury occurred	ecity)
Division	Dig after	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify		reet, factory, office			n (Street and Number or i Town, State)	Rural Route Number,
	한 부 표 수	edicai (29a. Certifier (Check only one) Certifying Physic 2 Medical Examine	cian: To the best of my known: On the basis of examinat and manner stated.	wledge, deat ion and/or in	th occurred at the to	me, date an opinion, deal	d place, and due to the tine	the cause(s) and manner ne, date and place, and d	as stated. ue to the cause(s)
	To the I within 2 To the I complet	×	29b. Signarure and title of certifier			29c. Licen	se number	_	29d. Date signer (Mod	nth, Day, Year)
F			30. Name and address of person who com	pleted cause of death (Item	23a) (Type	of Nor	e A	un dal 4	4/20/0 (cm) 2	1222,
	St Regist	ate rar	31. Date filed (Month, Day, Year) APR 2 1 2006	32. Registrar's Signal	ture		~ P			

			1 - For Registrar	State of Maryland / Depa	artment of Health and rtificate of Death	Mental Hygien	Z 11 11 1 1 Z 1 Z 1
	Physic /Medi		1. Decedent's Name (First, Middle, La Charlotte	st)	MILLER	2. Date of Death	20 2006 2 25 pm
	Exami		7 0-	IORIAL HOSPITAL	4b. City, Town, or Location of Dea BAITIMOR	th 4	4c. County of Death
	Funeral Director		5. Social Security Number 2/4-03-43/1 Usual Residence of Decedent	ex 7. Age (In yrs. last birthday) M 2AF 7 Yrs.	If Under 1 Year If Under 24 Hr. Months Days Hours Min		9. Birthplace (State or Foreign Country) 1919 MARY/AND
	hours after death with the Maryland tursi', or items 23a or 28a-f show at Exeminer must be notified at	Director	10a. State 10b. County MAMILY BALL 10e. Street and Number	10c. City, Town or Lo	Dien DACK	-	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	ath with	rai Dir	103 Center	Place = 214	2122Z	10g. C	Citizen of What Country? W. S. A.
920	ours after dea rai', or items Exeminer m	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Nover Married 2 Divorced	1 Yes 2 No	Vas Decedent of Hispanic Origin? (: f Yes, specify Cuban, Mexican, Puel I ☐ Yes 2 (X)No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
1215-0036	vithin 72 hours ne. han "netural", ne Madical Exe	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) 16a. Decec (Give life. L	lent's Usual Occupation kind of work done during most of wo DO NOT use retired) CLERK	nking	Kind of Business/Industry ONTGOMERY WARD
land 2	should be filed withir and Mental Hygisns. marked other than matic event, the M	To Be Co	17. Father's Name (First, Middle, Last)	Fenny	18. Mother's Na	me (First, Middle, Maide	en Sumame) HACK
Baltimore, Maryland	Heelth ar Heelth ar tem 27 is other trau		19a. Informant's Nam - Relationship (1) Sylva A Bu 20a. Method of Disposition 1≱Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification 1)	Type, Print) 19b. Mailin 19b. Mailin 19b. Mailin 20b. Place of Dispo- cemetery, cren 20c. Place of Dispo-	g Address (Street and Number or A Bridle LANC sition (Name of natory or other place)	Nottings Date 200. 1	or Town, State, Zip Code) AM MD Z1236 Location City or Town, State
Baltir	permit. Pages Department of Important: If i eny injury or once.		21. Signature of Funeral Service Licen		Name and Address of Facility	NNINO J	HIT NOTE, MARYLAND R. Fumen House BAHOMB ZIZZH
×	Cate be executed hysician and hysician and hysician and hysician and hybridian fransit.	Examiner	23a. Part1. Enter the disease, or cern shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		c or respiratory arrest,	Approximate Interval Between Onset and Death 2 Days
.O. Box 68760,	The law requires that the death certificate by the hes been signed by the attending physic bage 2 should be detached for use as the bind.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	d. 23c. If yes, outcome of pregnancy 1	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
ords, P.	w requires that been signed I should be det	ρ	Part II. Other significant conditions or	ontributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacco 1 ☐ Yes 2	use contribute to the cause of death?
of Vital Records,		Completed	05 W			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
f Vit	Physicien: This certificerral director, p	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 Kinpatient 2 ☐ ER/Outpatient	Othor	ath Check only one forme 5 Residence	6 □Other (Specify)
Division o	isi or Attending Ph s after death. ii Director: After th ed in by the funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how inju	
Divi	he Hospital or At in 24 hours after of he Funeral Direct pletely filled in by		4 Homicide determined	building, etc. (Specify)		City or Town, State	
	To the Hos within 24 hc To the Fun completely	edical	(Check only ane)	iner: On the basis of examination and/or invi and manner stated.	estigation, in my opinion, death occu	rred at the time, date an	id place, and due to the cause(s)
	To the To the Complet		29b. Signature and title of certifier Nay A	. Watt, no	29c. License number D 00 6365	29d. Da	ite signed (Month, Day, Year)
	Sta Registr	te	0	ompleted cause of death (Item 23a) (Type, F	on Memoria	il Hospit	ate signed (Month, Day, Year) (1) 20, 2006 Tal Baltimore, MD

			For State Registrar	State of Ma	ryland /		ent of He			giene () ()	6	12528
	Physici	an	1. Decedent's Name (First, Middle, Last)						2. Date of Dea	ath Day	Year	3. Time of Death
	/Medic Examin	al	Madeline Martin 4a. Facility Name (If not institution, give	street and number)		4b. (City, Jown, or	Location of Death	HWIL	4c. County	of Death	11:36' "
	Examili	e	Fo IIII. Co	are Hosi	pital		KOS.	edale		Ba	Hin	nore
	Funeral Director		5. Social Security Number 6. Sec	7. Age M 2 🖾 F	(In yrs. last b	Yrs. If U	ths Days	If Under 24 Hrs. Hours Min.	8. Oate of Birt (Month, Da Feb 24	y, Year)	9. Birthpla Countr MD	ace (State or Foreign y)
	D		218-36-8514 Usual Residence of Decedent						TED 24	, 1740		
	ehow	ក	10a. State 10b. County			wn or Location					10	d. Inside City Limits 1 ☐ Yes 2-☐ No
	death with the Maryland me 23a or 28a-f ehow r must be notilited at	Funeral Director	MD Baltime 10e. Street and Number	ore	Parkv		. Zip Code			10g. Citizen of V	Vhat Countr	y?
0)	th with	ralD	8209 Oakleigh Roa	ıd			21234			US		
\leq	ter deg	une	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N		13. Was D If Yes,	ecedent of His specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)		e - America k, White, e	
5-0036	72 hours after natural', or its ilesi Examiris	þ	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 □ Ye	es 2⊠ No	Specify:		Specify	Whit	:e
	"natu	Completed	15. Decedent's Edu (Specify only highest grad		16	a. Decedent's (Give kind o		uring most of work	in g	16b. Kind of Bu	siness/Indu	ustry
2121	within jiene. r than "	ошо	Elementary/Secondary (0-12)	College (1-4or 5-	+)	Secret	,			non-pr	ofit	
2	be filed tel Hygid d other	BeC	17. Father's Name (First, Middle, Last)					18. Mother's Nam	e (First, Middle,	Maiden Sumam	θ)	
\rac{\rac{1}{2}}{a}	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mentel Hyglene. Item 27 is marked other than "natural", or iteme 23a or 28a-1 show other traumatic event, the Medical Examinar must be notilized.	٦	John Charles Casp 19a. Informant's Name/Relationship (T)		19	b Mailing Ado		Alga Made			State. Zio (Code)
-₹	nd 2 she alth and 27 ie m rr traum		Cheryl Magness/da					ad Baltiı		-		
uttinore,	Pages 1 and 2 ient of Health int: if item 27 inty or other tra		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☑ Donation 5 ☐ Other (Specify)		20b. Place	of Disposition ery, crematory	(Name of		Date	20c. Location -	City or Tow	vn, State
Balti	permit. Pages Department of Important: If if any injury or o		21. Signature of Puneral Service Licens Ronald Service	/ -/	ctor	Stat	e Anato	s of Facility Omy Board MD 21201	1 655 W.	Baltim	ore S	treet
\geq			23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	ications that caused ne cause on each lin	the death. Do	not enter the	mode of dying	, such as cardiac	or respiratory a	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	none	-	-de	Ma				
	Examiner			Due to (or as a		cotic	Pressi	see.				
	₽ ≅	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence							
	axecute and al-tran	Examiner	that initiated events resulting in death) Last	Due to (or as	a consequence	e of):	Disea	5e				
38760,	icate be executed physician and s the burial-transit		(. meta	5+9-	tic_	Colo	on Co	incer			
Box 68	eath certifi ettending p	an/Me	23b. was decedent pregnant	23c. If yes, outcome		th 3⊡Ector	pic pregnancy			23d. Dat	e of deliver	•
	thet the death certific ed by the ettending p deteched for use as	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	time of death		or (specify)			MOI		Day Year
Division of Vital Records, P.O.	Sign Sign abe	Ď	Part II. Other significant conditions co	ntributing to death bu	ut not resulting	in the underly	ing cause give	en in Part I.	23e. Did t		ibute to the 3 ☐ Proba	e cause of death?
eco	e law requ has been je 2 shoul	Completed			17.				24a. Was	an 24b. V	Vere autop prior to com leath?	sy findings available
E E	ysician: The is certificete hadiector, page		25. Was case referred of medical		,			26. Place of Dea	1 ☐ Yes	2000 1	Yes 2	2□ No
Ş	Physicia this certi	To Be	avaminar?	Hospital: 1 Inpatie	nt 2□ER/0	Outpatient 3	DOA Othe)r		dence 6 □Oth	er (Specify))
o uo	itending Ph death. tor: After th the funeral	tlon:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injur (Month, Da)	y Year) 28b	Time of Injury	28c. Injury Work	vat ⟨? Yes 2∐No	28d. Describe I	now injury occurr	ed	
Divisi	of ter death of Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	ury - At home, c. (Specify)	farm, street, fa	actory, office		28f. Location (. City or Tou	Street and Numb wn, State)	er of Rural	Route Number.
	To the Hospital or Atten within 24 hours effer deat To the Funeral Director: completely filled in by the	ledical C		rsician: To the best of iner: On the basis of and manner sta	examination a							
	To the within To the comp	ž	29b. Signature and title of certifier	4.4	in		29c. License			29d. Date signer	(Month, E	Pey, Year)
			20 Nome and old way	1 My	11 U) (Type Pries)		0000		/ /	10	9
			30. Name and address of person who of Dr. Summit 6	upta 90		anklii	n 590	vare Dr	ive Bo	eltimo	re M	10.21237
	Sta Regist		31. Date filed (Month, Day, Year) APR 2 1 20	8.4	ar's Signature	for the	7				ı	

			State of I	-	artment of Health and lartificate of Death		ene 2006	12529
			Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	Physicia		Richard A. Noble, Sr.			April 18	Day Year	4:08 A ^M
	/Medic Examin	_	ta. Facility Name (If not institution, give street and numb	er)	4b. City, Town, or Location of Deat	h	4c. County of Death	
	CAMITI	-	Howard County General Hos	pital	Columbia		Howard	
	Funeral		5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth	(ear) 9. Birth	place (State or Foreign
	Director		274-34-3837 1₺M 2□F	67 Yrs.	Months Days From S	Feb. 19,	1939 Oh	
	p ,	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	shov							1 X Yes 2 □ No
	8a-f	Director	Ohio Cuyahoga 10e. Street and Number	North Olm	Sted 10f. Zip Code	100	g. Citizen of What Cou	ntnr?
	with th	훕			44070	,01	U.S.A.	11td y ?
	s 23	Funeral	4771 Clague Road	ent Ever in 11 S 13	Was Decedent of Hispanic Origin? (S	Specify Yes or No-	14. Race - Ameri	can Indian.
	item item	Š	11. Marital Status 1 □ Never Married 2 ☒ Married 1 ☒ Yes 2	es? 1057	If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	Black, White	
36	ir, or	by	3 ☐ Widowed 4 ☐ Divorced	1980	1 ☐ Yes 2 No Specify:		Specify: Wh	ite
21215-0036	72 hours after deeth with the Maryland naturel; or items 23e or 28e-f show dical Examiner must be notified at	De le	15. Decedent's Education	16a. Dece	dent's Usual Occupation	rtring 16	6b. Kind of Business/Ir	ndustry
215	hin 7;	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4)	life.	kind of work done during most of wo DO NOT use retired)			
21,	filed within Hygiene. Wher then "	E	4	Servi	ce Director	C	ity of Olm	sted Ohio
p	d 2 should be filed within h and Mental Hygiene. 7 is marked other then "traumatic event, the Mes	Bec	17. Father's Name (First, Middle, Last)		18. Molher's Na	me (First, Middle, Ma	aiden Sumame)	
<u>la</u>	uid b Menta rrked	10	Dominic Noble		Irene	Foreman		
Maryland	and I		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or R.			p Code)
	and all n 27		Bonita Noble (Wife)		Clague Rd., North			
ore	of Ho		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from St.	20b. Place of Disposate Ohr Place of Disposate	TETA RESERVE		Oc. Location - City or T	own, State
Ĕ	Pages ment of ant: if its ury or o		4 Donation 5 Other (Specify)	National	Cemetery 4/24		Rittman, O	H
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-f show eny figury or other traumatic event, the Mudical Examiner must be notified at Once.		21. Signature of Funeral Service Licencee.	_ 2	2. Name and Address of Facility Kacirek Funeral F	lome	o 1 OU 44	070
	40204		23a, Part1. Enter the disease, or complications that cau		29060 Lorain Rd.			Approximate
			shock, or heart failure. List only one cause on each	th line.			,	Interval Between Onset and Death
	Physician /Medical		disease or condition a. Athero		ardiovascular Dis	sease		
	Examiner		Due to (or	as a consequence of):				
н		ā		as a consequence of):				
	nslt	ulu u	cause. Enter Underlying Cause (Disease or injury					
•	execu n and ai-tra	Examiner	that initiated events c Due to (or	as a consequence of):				
8760,	certificate be executed ding physician and ise as the burial-transit	ca	L d					
9	ificat g phy as th	Physician/Medical						
Box	ndin use a	N W		me of pregnancy h 2 ☐ Fetal death 3[⊒Ectopic pregnancy		23d. Date of deliv	•
	es that the death certific igned by the attending p be detached for use as	icia	in the past 12 months?	nt at time of death 5	Other (specify)		Month	Day Year
P.O.	that the ed by the detache	hys	9 Unknown 9 Unknow	m				
	gned ge de	y P	Part II. Other significant conditions contributing to dea	th but not resulting in the t	underlying cause given in Part I.		icco use contribute to	37
rd	w requires been sign should be	Completed by	Diabetes Mellitus			1 🗆 Yes	2 No 3 Pro	bably 4 💆 Unknown
O O	5 0 6	plet				24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
Ä	The lav	E O				perform 1 Yes 2	ed? death? XNo 1 ☐ Yes	2□ No
ita	Physician: Th this certificate ral director, pag	Bec	25. Was case referred to medical examiner?			ath (Check only one)	
+	d is	To	1 ☑ Yes 2 ☐ No Hospital:	patient 2K ER/Outpatie	nt 3□ DDA Other: 4□ Nursing	Home 5 ☐ Resider	ice 6 □Other (Spec	ify)
0	ng Ph fter th neral	ü	27. Manner of Death 1 ☒Natural 5 ☐ Pending 28a. Date of (Month,	Injury 28b. Time of Injury	Work?	28d. Describe hov	v injury occurred	
9	endii eath. or: A the fu	atl	2 Accident investigation		M 1 Yes 2 No			
Division of Vital Records,	or Att	Certification:	determined 200. Flace	f Injury - At home, farm, si j, etc. <i>(Specify)</i>	treet, factory, office	281. Location (Stre City or Town,	eet and Number or Rui State)	ral Route Number,
۵	urs al	ပီ	¥ 0 7				(-)	
	To the Hospital or Attending Physician 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edical		is of examination and/or in	th occurred at the time, date and place nvestigation, in my opinion, death occurred.			
	Vithin O the	Me	29b. Signature and title of certifier		29c. License number	29	d. Date signed (Month	. Day. Year)
	0		K. A. A Mintim. M	D	D0057177		April 18,	2006
1	0		30. Name and address of person who completed cause	of death (Item 23a) (Type	, Print)			
-	J		Bert F. Morton, M.D. 28	02 Montclair	Dr., Ellicott C	ity, MD 21	.093	
	Sta	ite		nickenda Cimpotura				
	Regist	ar	APR 2 1 2006	w St Ages	wife .			

			For State Registrar	State of Ma	aryland		rtment of tificate of		Mental H	/gieņe Reg. No.	006	12530
	Physici /Medic	2	1. Decedent's Name (First, Middle, La	thalie	T.	Ne	w Con		2. Date of D Month	eath Day	. 2006	3. Time of Death
	Examir		4a. Facility Name (If not institution, given Howard County)	General	Hosp	ital		or Location of Deal		4c.	County of Death Howa	rd
	Funeral		Social Security Number 6.5		e (In yrs. lasi		If Under 1 Yea Months Days			ay, Year)		place (State or Foreign
e, Maryland Z1Z13-0030 1 and 2 should be filed within 72 hours after death with the Maryland	Director work	or	Usual Residence of Decedent 10a. State 10b. County Maryland Howard		10c. City, T		cation		Aprili	+ - 192-	+ riar	yland 10d. Inside City Limits 1
	or 28a	Director	10e. Street and Number		COTAIND	10	10f. Zip Code			10g. Citiz	zen of What Cou	intry?
	I within 72 hours after death with the Maryla liene. I then "natural", or lieme 23a or 28a-1 ehov The Mudical Exarticus roual te notified at	by Funeral	6336 Cedar Lane 11. Marital Status 1 Never Married 2 Married 3 St Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:		l:	21044 Vas Decedent of Yes, specify Cu	Hispanic Origin? (ban, Mexican, Pue o <i>Specity:</i>	(Specify Yes or Nerto Rican, etc.)		14. Race - Amer Black, White Specify: Whit	, etc.
	I within 72 hou liene. r then "natura I're Medical E	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12	ducation		(Give	ONOT use retii	e during most of w	vorking		nd of Business/li	ndustry
	be filed tal Hyg d othe event,	Be	17. Father's Name (First, Middle, Las	7)				18. Mother's N	ame (First, Middi	e, Maiden .	Sumame)	
	d 2 should th and Men 7 ie marke traumatic	T _O	Albert Ammann 19a. Informant's Name/Relationship Roy Newcomb, Son	(Type, Print)				Thelma Wet and Number or Hettom Road,	Rural Route Num	_		ip Code)
	Pages 1 and ment of Healt ant: If item 2 lury or other		20a. Method of Disposition 1 18 Burial 2 □ Cremation 3 0 4 □ Donation 5 □ Other (Special Control of Control	fy)	20b. Plac	e of Dispo etery, cren Cemet	sition (Name of natory or other p	Jace) 04/	Date 15/2006	20c. Lo	cation - City or T	
gall	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Lice	nsee Bt.			Name and Add	ress of Facility F andy Spring	leck Funer			
n of VItal Records, P.O. Box 68760, ng Physician: The law requires that the death certificate be executed	Physician // Medical Examiner and supply sicien and sicient and sicient and	Completed by Physician/Medical Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	enic a consequer a consequer	Obs		ying, such as cardi		arrest,	ease.	Approximate Interval Between Onset and Death
			IF FEMALE: 23b. Was decedent pregnant in the past 12 mpnths? 1 □ Yes 2 Selvo 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal de	ath 3	Ectopic pregnan Other (specify)	icy	NA	2	23d. Date of deliver Month	very Day Year
	luires that lhe de r signed by the a lid be detached f		Part If. Dther significant conditions TS Chemic	Colitis		ng in the ur	derlying cause g	given in Part I.		/		the cause of death?
	The law ate has b page 2 si		parkinson	is disea	ase.				24a. Wa aut per 1 \(\text{Yes}	s an opsy formed? 2 \ No	24b. Were aut prior to c death? 1 🗌 Yes	opsy findings available ompletion of cause of
	Physician: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	ot 2 🗆 🗆	VOutpatien	t 3 DOA	thor	leath <i>(Check only</i> Home 5 Re		S □Other /Spec	(6.1)
	ite e	atlon: To	27. Manner of Death 1 Maturaf 5 Pending investigation	28a. Date of Inju (Month, Da		Bb. Time of Injury	28c. In		28d. Describe			,,,,
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)									
	he Hos in 24 ho he Funi pletely f	Medical	29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	miner: On the basis of and manner sta	f examination ated.	and/or inv	restigation, in my	opinion, death oc	curred at the time	e, date and	place, and due	to the cause(s)
ì	To t To t	M	29b. Signature and title of certifier	hysician: To the best miner: On the basis o and manner st.	Mil),	29c. Lice	565	31	29d. Date	rid 12	, 2006
0	21		30. Name and address of person who Harry Li)	completed cause of d	leath (Item 2:	3a) (Type,	erint)	colum	bia, n	ND a	21044	
10.0	Sta Regist		31. Date filed (Month, Day, Year)	32. Registr	ar's Signatur		ander					
DH	MH 17 Rev 1/2	45	APR & I	ZUUDI OLA	18.1 18	-						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. cedent's Name (First, Middle, Last) 2. Date of Death Physician 10 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 24 Hrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthp **Funeral** NOM 20F Months Days Hours Min Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits is faired with and Mental Hygiene.
Item 27 ie marked other then "natural", or Items 23s or 28s-1 show ritem 27 is marked other then "natural", or Items 23s or 28s-1 show ritem traumatic event, the Medical Examinar must be natified at 1 Yes 2 No Funeral Directo more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? SH death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 11. Maritaf Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: WW II 1 Yes 2 No ģ Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) $_{\sim}$ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Nai towar 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Cod.) 19a. Informant's Name/Relationship (Type, Print) =11150TTCITY, MD 20b. Place of Disposition (Name of Du Date 20a. Method of Disposition 20c. Location - City or Town, State Depertment of Importent: if Its eny injury or of page. cemetery, crematory or other 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) rison tolo 21. Jignatur of Fundral Space Licen permit 22. Name and Address of Each pe 75 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician DIScone Parkinsons Seulal year /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertaing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician end for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of). P.O. Box 68760. Physician/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 DEctopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□ Unknown 9 Dunknown Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No hes page 2 certificete (anger 2 No 1 Yes To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospitaf: 1 Inpatient Other: 4 X Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Tes 2 🖰 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation within 24 hours after death. To the Funeral Director: A 1 Tes 2 🗆 No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicaf Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D27541 April 20, 2006 allton Layor MI) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pary Rd, Baltimon,

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Yeer)

32. Registrar's Signature

2006

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. U 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** April 19,2006 ear 4:30 AM MARGARET FRANCES NORWOOD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manchester 2866 Hilltop Drive Carroll 8. Date of Birth (Month, Day, Year) Aug. 20, 1934 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 25 F 71 219-30-0023 Yrs. Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow Manchester MD Carroll 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21102 USA 2866 Hilltop Drive ітеть 23а by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes 2X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: 3 ₩ Widowed 4 Divorced "netural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Efementary/Secondary (0-12) College (1-4or 5+) At Home Homemaker 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alice Patterson John Deinlein ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Pages 1 and 2 s Department of Health ar Important: if item 27 ie eny injury or othar trau once. Catherine Marie Bowler-Daughter 2866 Hilltop Drive-Manchester, Maryland 21102 20b. Place of Disposition (Name of cametery, cramatory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Gardens Of Faith 4-22-06 Rosedale, Maryland Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee EVANS CHAPEL OF MEMORIES 8800 Harford Road-Parkville, Maryland 21234 tadden 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. fmmediate Cause (Final disease or condition resulting in death) PANCYTOPENIA **Physician** /Medical Due to (or as a consequence of): Examiner LYMPHOMA Sequentiafly fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine physicien and s the burial-transit Due to (or as a consequence of) P.O. Box 68760, Completed by Physician/Medical ettending pt d for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death signed by the e 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ANEMIA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an page 2 autopsy performed? 1□ Yes 2₽No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To this ieral Director: After the filled in by the funeral 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturaf 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide To the Hospital o within 24 hours of To the Funeral D completely filled is 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) D0054580 30. Name and address of person who compfeted cause of death (Item 23a) (Type, Print) BALTIMORE ST M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 2 1 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month James A. Osteen Sr. April 16 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Ivy Hall Nursing Center Middle River Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth April 7,1919 Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 245-07-0910 87 Director Yrs NC Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, if a Medical Examinal must be nutified a once. 10d. Inside City Limits MD Baltimore Middle River Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 31 A Cedar Drive 21220 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 3 Married Baltimore, Maryland 21215-0036 1 Yes X No Specify:White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuaf Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry State of Elementary/Secondary (0-12) College (1-4or 5+) Construction North Carolina 6th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Curtis Osteen Lula Mae King 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Stallings 1420 Dr Jack Road Conowingo MD 21918 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Shephard Memorial 4/21/06 Hendersonville NC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signature of Funeral Service Licensee 0 Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or coordinations that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Infarct **Physician** Dementia disease or condition resulting in death) /Medical Examiner so vuscu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) attending physicien and for use as the burial-translt or Attending Physician: The law requires that the death certificate be executed tension that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. isigned by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Onknown Completed 1 ☐ Yes 2 ☐ No been 24a. Was an autopsy performed 1 Yes 2 24b. Were autopsy findings available prior to completion of cause of death? page 2 certificate 1 ☐ Yes 2 ☐ No director. 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ို 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Medical Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending Injury investigation hours after death. 1 ☐ Yes 2 ☐ No i Director: d in by the f 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospitai within 24 hours a
To the Funeral Completely filled pelli Certifying Physician: To the best of my knowledge death decurred at the time, date and place, and due to the eause(s) and minimizer as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0061907 4 18 06 ted cause of death (Item 23a) (Type, Print) Mace Avenue, Bultimore, hukwuma 31. Date filed (Month, Day, Year) State APR 2 1 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene [] [] [Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2006 April 15, **Physician** O'Connor Doris Α. 7:30 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 6116 84th Avenue New Carrollton Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct. | 29, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Yrs. Director 63 186-32-4042 1942 Pennsylvania Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Prince George's New Carrollton Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Hygiene. other than "natural; or items 23s or ; vant, the Madical Exeminar must be ; with 6116 84th Avenue 20784 U.S.A. deeth by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inner of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ites ury or other traumatic avant, the Madical Examination. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 🖾 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Medical Lab Technician Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Sopich Elizabeth Bocsy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia O'Connor (Daughter) 1014 Old Turkey Point Rd., Edgewater, MD 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of important: If any injury or once. Metropolitan Crematory 4/18/06 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hoffman Funeral Home 12mns Val men 409 Main St., Boswell, PA 15531 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician METASTATIC BREALT year s disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine The law requires that the death certificate be executed ettending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the e 9 Unknown certificate has been signed rector, page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 ₺ No 1 Yes 2 No 1 ☐ Yes Hospital or Attending Physician: After this certification 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 \(\triangle \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending efter death.

Diractor: Aft 1 ☐ Yes 2 ☐ No М investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital of within 24 hours of To the Funeral Discompletely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 050686 4/13/06 61166 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #124 MDZOTIS 14300 Gallant Fox Lane BOWIE GURDEEP S. CHHABRA, MD

DHMH 17 Rev 1/2001

State

Registrar

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32. Registrar's Signature

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Maryland 21215-0036	should nd Men marke	2	19a. Informant's Name/Relationship	(Type, Print)	19b Ma	iling Address /Stree			or, City or Town, State, 2	Zin Codo)	
			Mrs. Dolores Ost	rowski (w						21014	
ře,	s 1 a f Heg Item othe		20a. Method of Disposition		and the second s	position (Name of rematory or other pla	0,00000	Date	Maryland 20c. Location - City or		
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is eny injury or other tre		1 🖾 Burial 2 □ Cremation 3 [4 □ Donation 5 □ Other (Speci	Removal from State				17/2006	Baltimore,	Manuland	
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			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused one cause on each li	the death. Do not e	enter the mode of dy	ng, such as card	diac or respiratory ar	rest,	Approximate Interval Between	
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	/Medical Examiner	_	disease or condition resulting in death) a. SUBDURAL HEMATOMA (non tradmatic) 4 DAYS Due to (or as a consequence of):								
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m	it the death certific by the attending p		in the past 12 months? 1 🗆 Yes 2 🗆 No	4☐ Pregnant at		Other (specify)	у		Month	Day Year	
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Division of Vital Records, P.O. Box 68760,	w require been si		CHRONIC LYI	WINDOC Y-11	C LEUKE	EMIA		_ 1□Y	es 2 No 3 Pro	obably 4 Dunknown	
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ā	s after di s after di bl Direct ed in by t	ert	4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street City or Town, State City						n, State)		
	5 5 E E		29a. Certifier (Check only 2 Medical Example 1	nysician: To the best o	of my knowledge, dea	ath occurred at the til	me, date and pla	ace, and due to the c	ause(s) and manner as	stated.	
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	1 - State Registrar		/ Department of Health and Certificate of Death	Reg.	6000 16000				
Physician /Medical		esham Presley			Day Year 3. Time of Death				
Examiner Funeral Director	5. Social Security Number 417-38-1357	Sex To Age (In yrs. las		8. Date of Birth	4c. County of Death Portion RE 9. Birthplace (State or Foreign Country) 1928 Alabama				
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cete has been significate as should Completed				24a. Was an autopsy performed 1 ☐ Yes 2 🔀					
2 = E	25. Was case referred to medical examiner? 1 \(\times \) Yes 2 \(\times \) No 27. Manner of Death 1 \(\times \) Natural 5 \(\times \) Pending investigating investigating 3 \(\times \) Suicide 4 \(\times \) Homicide determined	On (Month, Day Year) 28e. Place of Injury - At hombuilding, etc. (Specify)	WOutpatient 3□ DOA Other: 4□ Nursing H 3b. Time of Injury 1□ Yes 2 ☑No	28d. Describe how in	t home				
Hospi 4 hou Funer ely fill	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
within 2	29b. Signature and title of certifier 30. Name and address of person who	o completed cause of openin (Item 2	29c. License number 5 47 30 3a) (Type, Print)	29d.	Date signed (Month, Day, Year)				
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ORIGINAL

				partment of Health and Me ertificate of Death	ental Hygie	2000 12331
	Physici	an	1. Decedent's Name (First, Middle, Last)	-		3. Time of Death
	/Medio	al	Edward F. Dinick, C 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	4c. County of Death
1	Examir	er	Meray Medical Center	Paltimore	4	Baltimore City
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Months Dave Hours Min	8. Date of Birth	ar) 9. Birthplace (State or Foreign
	Director		215-28-8636 TWM 2 TF 74 Yrs. Usual Residence of Decedent]	Feb. 18,	1932 Maryland
	yland		10a. State 10b. County 10c. City, Town or I	_ocation		10d. fnside City Limits
	e Mar	ctor	Maryland N/A	Baltimore		1X Yes 2 No
	with th	Dire	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	ne 23	Funeral Directo	1206 Armstead Way 11. Marital Status 12. Was Decedent Ever in U.S. 13	21205 Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto F	cify Yes or No-	U. S. A.
9	or Iter	Fun	1 ☐ Never Married 2 【 Married	If Yes, specify Cuban, Mexican, Puèrto F 1 ☐ Yes 2 ☒ No Specify:	Rican, etc.)	Black, White, etc.
5-0036	72 hours after deeth with the Maryland neturel', or Iteme 23a or 28e-f show diest Exeminat must be naiffied at	d by	3 Wildowed 4 Divorced Year or Dates 1 9 5 2 - 1 9 5 4			Specify: White
215-	nin 72 n "ne	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of workin DO NOT use retired)	10	. Kind of Business/Industry Department of
212	od within glene. er then "	Com	Efementary/Secondary (0-12) College (1-4or 5+) 8th Grade	Superintendent		Public Works
pu	be filed Ital Hygi Id other	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name		
Maryland	is 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. Item 27 is marked other than "neturel; or Iteme 23e or 28e-f show other traumetic event, the Medical Examinar must be muffled at	ဥ	Edward Dimick 19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Rural	rgaret El	
Ma	1 and 2 sho Health and Iom 27 is mother traum	ij		S. Robinson St., E		
ore,	of Head		20a. Method of Disposition 1 ☐ Buriat 2 Community Comm	position (Name of Damatory or other place)	ate 20c	. Location - City or Town, State
Baltimore	permit. Pag Department Important: I eny injury o		4 Donation 5 Other (Specify) Bayview	Crematory 04/19		Saltimore, Maryland
Bal	permit. Pages Department of Important: If I eny injury or one			22. Name and Address of Facility Sch 331 Brehms Lane, Bo		
	Physician /Medical Examiner	iner	23a. Part1. Enter the disease, or complications that caused the death. Do not eshock, or heart failure. List only one cause on each fine. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	preunonia (Pseudo	
,8760,	cate be executed physicien and the burial-transit	dical Examiner	cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d. Septice	ect Interta	٦.	3 minths
.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physicien and tage 2 should be detached for use as the burial-transit	Physician/Medical		□Ectopic pregnancy □ Other (<i>specify</i>)		23d. Date of delivery Month Day Year
Records, P.	w requires that been signed t should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
900	ne law red has bee ge 2 shot	Completed	Deep venous thrombosi	S	24a. Was an autopsy	24b. Were autopsy findings available
E B	W C4	Com	Hepatitis B		performed	prior to completion of cause of death? No 1 ☐ Yes 2 ☐ No
of Vital	Physician: Th this certificate ral director, pag	Be	25. Was case eferred to medicat examiner? Hospitaf: Hospitaf:	26. Place of Death		
of	g Phys er this eral dii	n: To	27. Manner of Death 28a. Date of Injury 28b. Time	ant 3 DOA 4 INDISING HOM	le 5 ☐ Residence 8d. Describe how in	6 □Other (Specify) njury occurred
sion	Attending I ir death. ector: After by the funer	atlo	1 Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	M 1 Yes 2 No		
Division	ospitel or Attend hours after death uneral Director: ly filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office 28	8f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	To the Hospitel or Attending Physicien: within 24 hours alter death. To the Funeral Director: After this certific completely filled in by the funeral director.	edicai	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal on the basis of examination and/or in and manner stated.	th occurred at the time, date and place, an nvestigation, in my opinion, death occurre	nd due to the cause d at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
	To t Com	Σ	29b. Signaturgiand title of certifier	29c. License number 0 40363	4	Date signed (Month, Day, Year)
8			30. Name and address of person who completed case of death (Item 23a) (Type Laura Pimentel. M)	eray medical C	enter (3. Homore, no
	Sta Begietr		31. Date filed (Month, Day, Year) 32 Registrar's Signature	and a		•
DH	Registr MH 17 Rev 1/20		APR 2 1 2006 Bases & By			

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

onathan Philip		1- For State Registrar	Department of Certificate of		and Mental		Reg. No. 20	06 12538			
Physici Medical Exami		1. Decedent's Name (First, Middle, Last) Jonathan Philip Pruitt				2. Date of De Month April 14,	Day Year	3. Time of Death 0329 hrs			
		4a. Facility Name (if not institution, give street and number)	4		n, or Location of De		4c. County of I	Death			
Funeral		4 Beltway Drive, Apt. 3, Bldg. 4 5. Social Security Number 6. Sex 7. Age ((In yrs. last birthday)	Sykesvil		Hrs 8 Date of F	Carroll	9. Birthplace (State or			
Funeral Director		220-21-7225 1 x M 2 F	17 Yrs.	Months		Ain.		Foreign Country) DC			
		Usual Residence of Decedent	0c. City, Town or Locati), 1,000				
ow any		10a. State 10b. County Carrol1	e			10d Inside City Limits 1 Yes 2 X No					
faryland 28a-f show at once,	Director	10e. Street and Number	- 5710	esvill		I	10g. Citizen of What				
th the Maryland 23a or 28a-f she notified at once		4 Bethway Drive #3		2	21784		USA				
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiest and Paryland; a raise and a raise of the Table 18 or 188-f she matter of the Medical Examiner must be notified at once matter event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Married 12. Was Decedent Evaluation Armed Forces?	If Ye		of Hispanic Origin? (uban, Mexican, Pue		14. Race - / White, e	American Indian, Black, etc.			
fter des		1 Yes 2 X	No 1	Yes 2X	No specify:		Specify: W	nite			
nours a	eted by	15. Decedent's Education (Specify only highest grade compl	during me		cupation (Give kind		16b. Kind of Busin	ness/Industry			
36 hin 72 l e. than "u	plet	Elementary/Secondary (0-12) College (1-4 or 5+))	Studer		otti od)	Educat	tion			
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Comple	17. Father's Name (First, Middle, Last)	<u> </u>		18.Mother's Na		Maiden Surname)				
ID 21215-0036 should be filed within 72 hours after and Montal Hygiers, 75 is nuarked other than "natural", in surked other than "natural", in antic event, the Medical Examiner.	o Be	Richard a. Pruitt	1 10h Mailwa	Address //	Snar	on Nevit	T				
and 2 shou lealth and N tem 27 is n traumatic	ř	19a Informant's Name/Relationship (Type, Print) (Pare Mr. & Mrs. Richard Pruitt	ents) ¹⁹⁵ Manny 4 Bet	hway I	orive #3	Sykesvil	le, MD 21	State, Zip Code)			
프로드리		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	20b. Place of Disposi	ition (Name o	of cemetery,	Date	20c Location - C				
Baltimore, permit. Pages ar Department of Hee Important: If ite		4 Donation 5 X Other Specify: Entembrent	Sunset Me					ville, PA			
Baltimo permit. Page: Department o Important: injury or oth		21. Signature of Funeral Service Licensee Sulan K. Walf it	TÁI Sv	ame and Add GHT FU kesvil	ress of Facility INERAL HOL 1e. MD 2	ME & CHA 1784 (41	PEL, PA (1 0) 795-140	Box 195)			
Physician /Medical		23a. Part I. Enter the disease, or complications that caused th failure. List only one cause on each line.	e death. Do not enter th	ne mode of dy	ying, such as cardia	c or respiratory a	rrest, shock, or heart	Approximate Interval Between Onset and			
xaminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence)	mmediate Cause (Final disease a Narcotic and Methadone intoxication								
The same of the sa		Sequentially list conditions, b.		4.,							
	nine	if any, leading to immediate Due to (or as a consequence. Enter U. Jerryl, y Course C.	uence of):								
ed	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the conseq	uence of):								
execut ian and al - tra		X UNPENDED AMENDED item	#23a,27,28a-f	,perME,	g855 , 5/1/06	TT					
760, cate be exe physician the burial -		IF FEMALE: 23c. If yes, outcome	of pregnancy				23d Date of de	livery			
Box 6876 death certificate the attending phy	cian	23b. Was decedent pregnant in the past 12 months?	me of death	al death ner (Specify)	3 Ectopic preg	gnancy	Month	Day Year			
Box e death the atto	hysi	1 Yes 2 No 9 Unknown g Unknown									
, P.O.	by P	Part II. Other significant conditions contributing to death b	out not resulting in the u	nderlying cau	use given in Part I.			te to the cause of death? Probably 4 Unknown			
ds, equires een sig						24a. Was		re autopsy findings available			
Records, The law require ficate has been si	Completed			-			ormed? dea				
tal Rection: The certificate ector, page	a)	25. Was case referred to medical		26.F	Place of Death (Che	1 Yes	2 No 1	Yes 2 No			
of Vital 1g Physiciau: (fret this certi	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient				sing Home 5	Residence 6 🗸	Other: Scene			
on of	ion:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year	n)	1	Injury at Work? Yes 2 X No	28d. Describe	how injury occurred				
Division tal or Attendi rs after death al Director: A	ficat	2 Accident Investigation FIII 4/14/20	y - At home, farm, stree	Alt		28f Location	(Street and Number of	or Rural Route Number, City			
Diversal of	Certification:	4 Homicide determined (Specify) Four	nd: residence			Bldg. 4	Sykesville,	Dr. Apt 3			
Division of Vital Records, P.O. Box 68760, within 14 hopital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the timeral director, page 2 should be detached for use as the burial - trans	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my k Medical Examiner: On the basis of examiner.									
To To CON	Me	29b. Signature and title of certifier			cense number			(Month, Day, Year)			
9		Mayout Melfall		0	.C.M.E.		April 15, 2006	3			
7)	İ	30. Name and address of person who completed cause of dea Margarita Korell MD. Assistant Medical E		enn Street	t, Baltimore, MI	D 21201					
	tate	31. Date filed (Month, Day Year) 32. Jegistrar's	Signature		.,						
Regis	trair	APR 2 1 2006	1 B. Ange	41							

			1 - For State Registrar	ate of Maryland /	Department of Health Certificate of Deal	rn -	ene 006 12539
ı	Physici	an	Decedent's Name (First, Middle, Last)	PUN	CTOR	2. Date of Death Month	Day Year 3. Time of Death
}	/Medic Examin	al	ELISE 4a. Fecility Name (If not institution, give street	t and number)	4b. City, Town, or Location	on of Death	/ 2006 / 5 / 4M 4c. County of Death
			WASHINGTON ADVEN			PAPK.	MONTGOLLERY
f	Funeral Director		5. Social Security Number 6. Sex 1	7. Age (In yrs. last bi	Yrs. If Under 1 Year If Un	der 24 Hrs. s Min. 8. Date of Birth (Month, Day, Aug 31,	9. Birthplace (State or Foreign Country) unk
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov	wn or Location		10d. Inside City Limits
	e-f sh	ctor	MD Montgomery	Ade	lphi		1 □ Yes 2√ No
	a or 28	Dire	10e. Street and Number 1801 Metzerott Road	4	10f. Zip Code 20912	10	g. Citizen of What Country? USA
	death	Funeral Director	11. Marital Status 12. W	Vas Decedent Ever in U.S.	13. Was Decedent of Hispanic	Origin? (Specify Yes or No-	14. Race - American Indian,
936	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "naturel", or items 23a or 28e-1 show eumetic event, the Marical Examination of the marked and the marked at the marked a	by	1 X Never Married 2 ☐ Married 1	.rmed Forces? □Yes 2∑No Yes, Give 'ear or Dates:	If Yes, specify Cuban, Mexi		Black, White, etc. Specify: black
2-0	72 hou 'nature	eted	15. Decedent's Education (Specify only highest grade con	n 16a	Decedent's Usual Occupation (Give kind of work done during m	unk 1	6b. Kind of Business/Industry unk
121	within iene. then	Completed		ollege (1-4or 5+)	life. DO NOT use retired)		
aryland 21215-0036	be filed tal Hyg d other event,	Be	17. Father's Name (First, Middle, Last)		unk 18. Mo	other's Name (First, Middle, M	aiden Sumame) unk
aryla	should nd Mer marke imarke	To	19a. Informant's Name/Relationship (Type, F	Print) 191	b. Mailing Address (Street and Nun	mber or Rural Route Number,	City or Town, State, Zip Code)
2	and 2 salth a n 27 is		Washington Adventist	Hospital	7600 Carroll Ave		
ltimore,	ages 1 int of He t: If iten / or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 Removed to the Control of Total Control of C	val from State	of Disposition (Name of ary, crematory or other place)	Date 2	Oc. Location - City or Town, State
a	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumetic evonce.		4 □ Donation 5 □ Qother (Specify) 1: 21. Signatury of Funeral ervice Licensee ROn 1 Ld 5 • Wac		State Anatomy	Board 655 W.	Baltimore Street
m T	20 5 5 8		23a. Part 1 Enter the disease, or complication	Male	Baltimore, MD	21201	
	Pnysician		shock or heart failure. List only one ca	use on each line.			Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a consequence	EROTIC CARD. of):	IUNSCOUR	. Wisers
	LAGIIIIICI	ler	Sequentially list conditions, bb.	Due to (or as a consequence	of):		
	ecuted ind transit	Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
58760,	icate be executed physician and s the burial-transit	edical Ex	d d	Due to (or as a consequence	of):		
_			IF FEMALE:				
Box	leath certifi attending	Physician/M	23b. Was decedent pregnant in the past 12 months?	yes, outcome of pregnancy □Live birth 2 □ Fetal death □ Pregnant at time of death	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
д О	at the de by the a stached	hysi	9 Unknown 9	Unknown			
_	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	þ	Part II. Other significant conditions contribu	ting to death but not resulting i	in the underlying cause given in Pa		acco use contribute to the cause of death? 2 □ No 3 □ Probably 4 ☑ Unknown
Records,	aw requisible been 2 shouk	Completed				24a. Was an	24b. Were autopsy findings available
	sicien: The law certificate has t irector, page 2 s	Com				autopsy perform 1 🗆 Yes 2	prior to completion of cause of death? No 1 □ Yes 2 □ No
VIE	sicien s certifi irector	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 □ No Hospit	al: 1 ☐ Inpatient 2 Ø ER/O		ace of Death (Check only one) Nursing Home 5 - Residen	
Division of Vital	ng Phy fter this neral d	\vdash		a. Date of Injury 28b.	Time of 28c. Injury at Injury Work?	28d. Describe how	
SIO	ttendii death. stor: A / the fu	icati	2 Accident investigation 3 Suicide 6 Could not be	e. Place of Injury - At home, fa	M 1 Yes 2		et and Number or Rural Route Number,
2	s after al Direct	Certification:	4 Homicide determined	building, etc. (Specify)	arm, street, factory, office	City or Town,	
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p	Medical ((Check only 2 Medical Examiner: (n: To the best of my knowledge On the basis of examination ar and manner stated.	e, death occurred at the time, date nd/or investigation, in my opinion, d	and place, and due to the cau leath occurred at the time, dat	ise(s) and manner as stated. e and place, and due to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	7	29c. License numbe	er 290	d. Date signed (Month, Day, Year)
			CARO	- MB	603	19	04, 11,2006
			30. Name and address of person who compte				
	Sta		31. Date filed (Month, Day, Year)	AMMER 32. Registrar's Signature	Colle		
	Registr	ar	APR 2 1 2006	100000 10 17			

State of Maryland / Department of Health and Mental Hygiene, For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month APRIL Physician RAUCHEISEN OSKAR 2006 18 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Bon Secours Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F 75 217-40-6447 Yrs Director 01/21/1931 Germany Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location other than "natural", or items 23a or 28s-f ehow vent, the Medical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? #1 Six Notches Court 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hospitality Elementary/Secondary (0-12) College (1-4or 5+) Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mental ie marked Michael Raucheisen Hedwig Schwalm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 s
Department of Health ar
Important: If item 27 ie
any injury or other trau Michael Raucheisen/Son #1 Six Notches Ct. Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Apr 20 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory Inc. 2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives Cremation and Funeral Alternat 8717 Green Pastures Drive Bal 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8717 Green Pastures Drive Baltimore, Maryland 21286-Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** B11ATERA2 PNUEMONIA 2 PA73 /Medical Due to (or as a consequence of): Examiner ARTERIOSCLEROTIC HEART DISTASE UNTENUINA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed 11 HYPERTENTION Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) ed by the a o 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by DISEASE PARKINSONS 1 Yes 2 No 3 Probably 4 Nonknown DIABETES MELLITUS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? RENAL INSUFFICIENCY certificete 1 ☐ Yes 2 ☐ No 1 Yes 2 1€ No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28c. Injury at Work? Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Hatural Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 23300 us. APRIL 18 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) おoN ろたのレーカ) ヒット, 2000 W. BALTU, ST. 13A2TU, MD. SUDHIRID, PATELI 21223 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 2 1 2006 Registrar

		-	For State Registrar	State of M	Maryland / Dep <i>Ce</i>	artment of F rtificate of		l Mental Hy	ygieņe Reg. No.	16	12541	
	· 蒙···································		1. Decedent's Name (First, Middle,	Last)				2. Date of D		Yeer	3. Time of Death	
	Physicia /Medic	al	Carmeline	R.		Savage		April	17, Day 200		8:30 P M	
	Examin		4a. Facility Name (If not institution,			1	or Location of De	ath	th 4c. County of Death N/A			
			Johns Hopkins -		enter Age (In yrs. last birthday	Balti		rs. 8. Date of B		,	place (State or Foreig	
	Funeral Director		220-20-8931	5. Sex 1 □ M 2 💢 F	77 Yrs.	Months Days	Hours M	in. Septemb	er 5, 1928	Cou	PA.	
	and w	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits	
	f sho	5	Maryland Baltin	nore	Dunda.	Lk					1 ☐ Yes 2X No	
	the 1	rec	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Co.	intry?	
	3a o	O E	443 Pembrooke B	Lvd.		21	224		USA			
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23s or 28e-f show says injury or other traumatic svent, I'm Medical Exercitival count to notified at ODGe.	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deceder Armed Force d 1 Tyes 2	0 No	Was Decedent of If Yes, specify Cub		(Specify Yes or Nerto Rican, etc.)	Io- 14. Ra Bla Speci	ck, White	rican Indian, o, etc. Vhite	
3	2 hou		15. Decedent's	Education	162 Door	edent's Usual Occu	pation	working	16b. Kind of E	Business/I	ndustry	
2	hin 7.	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-40	life.	e kind of work done DO NOT use retire	ed)	working				
7	or thu	Con	12 years	4 Years	Le	gal Secre				Off:	ice	
3	tal Hydra doth	Be (17. Father's Name (First, Middle, L					Name (First, Midd lle Penne		me)		
7	ould Men varke	၉	Charles Baglione		*OF 14-:	ling Address (Stree	L			Stato 7	in Code)	
	12 sh h and h and 7 is m		19a. Informant's Name/Relationshi		į.	Pembrooke					<i>p</i> 2000)	
, ע	1 and Health		William Savage 20a. Method of Disposition	Husband	20b. Place of Disc	osition (Name of			20c. Location		Fown, State	
2	nt of l		1973 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 Removal from Sta	te Cemetery, cri	ematory or other pla n Cemeter		ril 21,	Dundal	le MI		
	permit. Po Depertme Importent sny injury		21. Signature of Funeral Service L		00	22. Name and Addr	ess of Facility Funeral	2006 Home Of	Dundal Dundalk	.P.A	•	
_	₫ O = 0		grenory	<u> </u>	muly	7110 Soll	ers Poi	nt Road,	Dundalk	,Ma.	Z I ZZZ Approximate	
			23a. Part1. Enter the disease, br c shock, or heart failure. List of		i line.	nter the mode of dy	Ing, such as care	and or respiratory	arrest,		Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition resulting in death)	a		o cardi	21 117	31011	54		One day	
	/Medical Examiner	ý	resulting in death)	Due to (or	as a consequence of):							
		er	Sequentially list conditions, if any, leading to immediate	bDue to (or	as a consequence of):							
T	ted nsit	n in	cause. Enter Underlying Cause (Disease or injury that initiated events	1								
	ayecu al-tra	Examin	that initiated events resulting in death) Last	Due to (or	as a consequence of):							
S S	ate be executed hysician and the burial-transit	cail		d								
00	ifficate g phys as the											
O. DOX	uires that the death certificate be executed signed by the attending physician and Id be detached for use as the burral-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown		2 ☐ Fetaf death 3 t at time of death 5	☐Ectopic pregnan	су			ate of deli ionth	ivery Day Year	
ŗ	that the led by th detache		Part ff. Other significant condition	ns contributing to deat	h but not resulting in the	underlying cause g	iven in Part I.	23e. Di	d tobacco use co	ntribute Io	the cause of death?	
S	requires heen sign	d by						10	☐ Yes 2 ☐ No	3 🗆 Pr	obably 4 Unknow	
ecoras	- 40	Completed						24a. W	as an 24b topsy	. Were au	itopsy findings available	
r	The ate h page	DO.						pe 1 ☐ Yes	rformed? 2 ⊠ No	death? 1 ☐ Yes	2MNo	
N I I	ysician: Th is certificate director, pag	Be (25. Was case referred to medical examiner?			10		Death (Check onl	y one)			
5	Physician: this certific ral director,	မ	1 ☐ Yes 2 🔭 No	Hospital: 1 🗆 Inp.		ent 3L DOA		ng Home 5 □ Re			cify)	
	a fe	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	3	njury 28b. Time Day Year) fnjury	W	uryat ork? ⊒Yes 2.⊟No	280. Describ	e how injury occu	11190		
<u>s</u>	Attending ir death. ector: After by the fune	cat	2 Accident investig	ot be 200 Stoop of	Injury - At home, farm,			28f. Location	Street and Nun	per or Ru	ural Route Number,	
DIVISION	or A efter Direct in by	Certification:	4 Homicide determi	building.	, etc. (Specify)	street, ructory, emo	,		Town, State)			
_	To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	Medical Co	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the be Examiner: On the basi and manner	est of my knowledge, de s of examination and/or	ath occurred at the investigation, in my	time, date and propinion, death of	lace, and due to the occurred at the time	ne cause(s) and ree, date and place	nanner as	stated. to the cause(s)	
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. Lice	nse number		29d. Date sign	ed (Mont	h, Day, Year)	
	+ 3 + ŏ		1 Son Cr	mom	MA	15	3156		4-1	9 - 2	006	
	15		30. Name and address of person	who completed cause	MD of death (Item 23a) (Typ 5 4 iistrar's Signature	e, Print)	4120	Cocker	15v.16.	10	2/030	
. ^	1		Jon E SIA 31. Date filed (Month, Day, Year)	32 Pm	istrar's Signature	1-911-1	170M		- 4/110 .	1		
	Regist	ate rar	APR 2 1	2006	we de de	certi						

DHMH 17 Rev 1/2001

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			1 - For State Registrar	St	ate of M	laryland /		artment of H tificate of I		Mental i	Hygie.	CUUb		12542
	Dhysia		1. Decedent's Name (First, Midd							2. Date o	Death	Day V	200	3. Time of Death
	Physici /Medi		Isabel	2	STON	E				Apr	11		ear ₆	3.40 PM
7	Examir		4a. Facility Name (If not institution	on, give stree	t and number	r)		4b. City, Town, or	Location of De	ath		4c. County of [Death	
			Ellico	tt City H	ealth & R	ehab Cent	er			licott City			Hov	vard
	Funeral		5. Social Security Number	6. Sex 1 ☐ M	2 A F 7. A	lge (In yrs. last i		If Under 1 Year Months Days	If Under 24 H Hours M		Birth Day, Yes	ar) 9.	Birthp	lace (State or Foreign
и	Director		167-34-7264	I I M	2/54	91	Yrs.			Septemb				nnsylvania
	and *		Usual Residence of Decedent 10a. State 10b. Count	,	-	10c. City, To	wn or Lo	cation						Od. Inside City Limits
	faryl	5												1 Yes 2 No
	28a-	Director	Maryland 10e. Street and Number	Howard	<u> </u>				icott City		10-	014		
	with		111					10f. Zip Code	04040		10g.	Citizen of Wha		•
	eath	eral	4084 Arjay Circle	12 1	Vac Docodos	it Ever in U.S.	12.1	Man Depodes of H	21042	/C	- N -		U.S./	
36	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show sideal Eyammer must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	rried 1	med Forces ☐ Yes 27 Yes, Give	ZNo	'	Vas Decedent of Hi f Yes, specify Cuba I□ Yes 25 No	spanic Origin / n, Mexican, Pu Specify:	erto Rican, etc.)	14. Race - / Black, V Specify:	White,	
21215-0036	hour tural	pe		nt's Educatio	ear or Dates		Dogo.	lent's Usual Occupa	tion.		4.01-	Kind of Bunin		
15	S 1 3	Completed	(Specify only high	est grade con	npleted)		(Give	kind of work done of NOT use retired	luring most of v	vorking	160.	. Kind of Busin		,
12	within lene. than "	mc	Elementary/Secondary (0-12) unk	0	College (1-4or	r 5+)			nemaker			O	wn H	lome
	Hygie other		17. Father's Name (First, Middle	, Last)				11011		lame (First, Mic	idle. Maid	len Surname)		
Maryland	Mental Mental arkad o	To Be	Ro	bert Mal	colm					Λ.	lan/Er	ngles Gray	,	
Z	E B E E	-	19a. Informant's Name/Relation			15	9b. Mailir	g Address (Street a	and Number or			,		Code)
	and 2 : salth ar n 27 is ier trau		Mrs. Carole Finke	doon	Dougl			084 Arjay Circ					-, -,-	,
ē,	Health tem 27 other tra		20a. Method of Disposition		Daugh	20b. Place	of Dispo	sition (Name of		Date		Location - City	or To	wn, State
no	00-		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3 🗀 Remo	val from State	е сете	tery, cren	natory or other place	· 1	MIDDIDDO				
Baltimore,			21. Signature of Funeral Service	-				ew Cremator Name and Addres	y	04/20/2006	- 1	Bait	more	e, MD
B	permit. Departr Importa any inju		Mullelle	Ale				01 1 5		ne, P.A.				
			23a. Part1. Enter the disease of hock, or heart failure. Lis	r complicatio	ns that cause	ed the death. De	o not ente	3871 Of or the mode of dying	d Columbi , such as card	a Pike Ellik iac or respirator	cott Cit	y, MD 210	43	Approximate
	Dhysisian		Immrediate Cause (Final	t only one ca	use on each	line.	0.01	" Cara	linVast	100 1	181	are		Interval Between Onset and Death
A	Physician /Medical		disease or condition resulting in death)	a	Duo to /or a	s a consequenc	croi	ce cuia	War	way k	/ I DC	00		
	Examiner				Cond	sa consequence	9 OI).	ic Cara	ailin	Q -				
		er	Sequentially list conditions, if any, leading to immediate	b	Due to (or a	s a consequenc	e of):	0	00000					
	uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	S										
o,	exec an an rial-tr		resulting in death) Last	C	Due to (or a	s a consequenc	e of);							
68760,	ificate be executed g physician and as the burial-transit	edlcal												
_	= O m													
Вох	death certifi e attending I id for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant			e of pregnancy 2 Fetal dea	th 3	Ectopic pregnancy				23d. Date of	delive	y
	0 00 0	Sicie	in the past 12 months?	4	Pregnant a	at time of death		Other (specify)				Month	-	Day Year
P.0	requires that the de een signed by the a nould be detached t	hys	9 Unknown	9	Unknown									
S,	w requires that been signed to should be det	by F	Part II. Dther significant condit	ons contribu	ting to death	but not resulting	in the un	derlying cause give	n in Part I.	23e. D	id tobacco	o use contribut	e to the	e cause of death?
rd	en si									. 1	☐ Yes	2 □ No 3 □] Proba	ably 4 Miknown
of Vital Record	aw as b	ompleted								24a. W		24b. Were	autop	sy findings available
Ä	о <u>г</u> б	mo								al pi 1 ☐ Ye	utopsy erformed? s 2	deati	h?	npletion of cause of 2□ No
ita		Se C	25. Was case referred to medica	at I					26. Place of D	eath Check on		40 10	03 4	2 140
>	S 0 5	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospi	tal: 1 🗌 Inpat	ient 2 ER/C	Outpatieni	3□ DOA Othe		Home 5□R		6 □Other (S	Specify)
	ding Ph th. After thi funeral		27. Manner of Death		a. Date of Inj		. Time of	28c. Injury Work				jury occurred	, , , , ,	
0	Attending ir death. ector: After by the fune	atlo	1_Natural 5 Pendi 2 Accident invest	ng igation	(Mornin, D	ay rour,	irijury		: ′es 2□No					
Division	or Attendater death Director: in by the	tific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern		e. Place of Ir	njury - At home,	farm, stre	et, factory, office			n (Street : Town, Sta		Rural	Route Number,
Ö	tal or A	Certification:		1	Dullding, c	no. (Openny)				Only G	10W1, 316	110)		
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical (29a. Certifier 1 Certifyi (Check only one) 2 Medical	Examiner: (n: To the besi On the basis and manner s	of examination a	ge, death ind/or inv	occurred at the tim estigation, in my op	e, date and placinion, death oc	ce, and due to t curred at the tin	he cause ne, date a	(s) and manner nd place, and	as sta	ited. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certific	er ^				29c. License				ate signed (M		
	0			E Ola	um			D.	30641	ſ	An	il 20	2	006
6	- 0		30 Name and address of person			death (Item 23a) (Type, F	Print) B	/	0 0	D	11	~	006 lay lat 2 px
7) Sta	te	Ramesh Sak 31. Date filed (Month, Day, Year		lhi 32. Regist	geath (Item 23a 20/- (0 trar's Signature	1 13	GCK KIVES	Neck	Koou	10a	Thuer	e H	104 lat 2 122
	Registr		APR 2	1 2006	Die	trar's Signature	Ga	Me						

			1- For State of Maryland / Dep	artment of Health and Mertificate of Death		PP-0 0 6	12543
	Dh. da		Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Truxon M. Syk	T	4	15 2006	6:00 a. M
	Examir	ier	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	1
			Manor Care 5. Social Security Number 6. Sex. 7. Age (In yrs. last birthday	Towson If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Balto 9 Birth	polace (State or Foreign
	Funeral Director		220-38-9707 1 [™] 2□F 62 Yrs.	Months Days Hours Min.	6-21-19	943	nplace (State or Foreign untry) Md
11	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Manyl f sho	ō	Md N/A Balto				V∏Yes 2∏No
	28a-	rec	Md N/A Balto 10e. Street and Number	10f. Zip Code	100	j. Citizen of What Co	untry?
	h with	O IE	4830 Greenspring Avenue	21209		U S A	
21215-0036	ges 1 and 2 should be tiled within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other then "natural", or Itams 23a or 28a-f show or other traumatic event, the Modified Exam reminish by modified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 2 Never Ma	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2X No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: B1	e, etc.
0	72 hor	ted	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation a kind of work done during most of worki	ina	b. Kind of Business/I	*
215	thin 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	N	ortheast	Community
21	filed within Hygiene.		12th grade 2 years	Community Organize		Organizer	
land	12 should be fitted within hand Mental Hygiene. 7 is marked other then "traumatic event, the Mas	To Be	17. Father's Name (First, Middle, Last) Raleigh Rockford Sykes		e (First, Middle, Ma th Parham		
Maryland	nd 2 shoulth and N			ing Address (Street and Number or Rura O Greenspring Avenu			
ē,	t Health Hem 27 I		20a. Method of Disposition 20b. Place of Disposition	osition (Name of Ematory or other place)	Date 20	c. Location - City or	Town, State
9	Pages nent of I int: If It		1X_Burial 2 Cremation 3 Hemoval from State 4 Donation 5 Other (Specify) Garriso	n Forest Vet 4-21-	-2006 O	wings Mil	ls, Md
Baltimore,	permit. Pages Department of Important: If It any Injury or o		21. Signature of Fungral Service Licensee	22. Name and Address of Facility Ma 4300 Wabash	rch West Avenue	F/H Balto, Md	21215
>	Physician /Medical Examiner		23a. Part. Enter the disease, or complications that caused the death. Do not explose, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or and a consequence of):	oter the mode of dying, such as cardiac o	or respiratory arres	t.	Approximate Interval Between Onset and Death
8760,	eath certificate be executed attending physician and for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):				
P.O. Box 68	0 0	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of deli	very Day Year
	s that gned b		Part II. Dther significant conditions contributing to death but not resulting in the		23e. Did toba	cco use contribute to	the cause of death?
ord	w require been signated should b	ed	nutastasis to bone, med	jasthum.	1 🗹 Yes	2 No 3 Pro	obably 4 Unknown
of Vital Records,	The la cate has page 2	Completed by	Circhesis, ESRD, HCV		24a. Whas an autopsy performs 1 Tes 2	prior to death?	topsy findings available completion of cause of
/ita	ysician: This certificate director, pag	Be	25. Was case referred to medical examiner? Hospital:	Othor	h (Check only one)		
of	Physic this c	10	1		me 5 Residence 28d. Describe how	ce 6 Other (Spec	oify)
DO		tion	1 Natural 5 Pending (Month Day Year) Injury	of 28c. Injury at Work? M 1 Yes 2 No	200. 2000.00	,,	
Division	or Attentiter deat inector; n by the	Certification;	2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director; After completely filled in by the fune	ical Ce	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or)				
	the I	Medical	one) and manner stated. 29b. Signature and title of certifier	29c. License number	790	I. Date signed (Monti	n. Dav. Year)
\	5 <u>1 2 0</u>		DATE M	0 041104		120.	4
h	1		30. Name and address of person who completed cause of death (Item 23a) (Type), Print)			
	V		led took (80) York to	Towson	1 < 170	T .	
	Sta Regist		31. Date filed (Month, Day, Year) APR 2 1 2006				

DHMH 17 Rev 1/2001

06-02641 Please Type or Print in Black Indelible Ink Lucille Mary Smith State of Maryland / Department of Health and Mental Hygiene 2006 1- For State Certificate of Death Registrar 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ 1620 hrs Medical Examiner April 18, 2006 4a Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Interstate 95 at Mile Marker 81.5 Harford Aberdeen Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or **Funeral** Foreign Months Days Hours Min. Director Countr Many Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 3nv Yes 2 No s 23a or 28a-f show profified at once. hours after death with the Maryland Director 10f. Zip Code 10g. Citizen of What Country 10e. Street and Numbe Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Black other than "natural", or items must be Armed Forces? White, etc. 2 Married Never Married No Yes White 2 V No specify Widowed 4 Divorced If Yes, Give Year Yes Specify traumatic event, the Medical Examiner à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) be filed within 72 Baltimore, MD 21215-0036 of Health and Mental Hygiene 18.Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) If item 27 is marked Be City or Town, State, Zip Sode 4 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Husband) Method of Disposi 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State or other crematory or other place 2 Cremation 3 Removal from State permit Pages
Department o Evans Donation 5 Other Specify 22. Name and Address of Facility Evans chature of Funeral Service Licensee pmblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** 23a Part I Enter the disease, or failure. List only one cause Between Onset and /Medical Death a Multiple Injuries Immediate Cause (Final disease `xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last attending physician and or use as the burial - transit Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 V Unknown Unknown contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has page 2 performed? death? ✓ Yes 2 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) To the Hospital or Attending Physician: Be Hospital: 1 Other₄ Nursing Home 5 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other: Scene 1 V Yes 28a Date of Injury (Month Day Year) Apr 18, 2006 28d. Describe how injury occurred 27 Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification Driver of auto struck fixed object 1615 hrs Natural Yes 2 V No Pending 24 hours after death. To the Funeral Director: completely filled in by the 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide determined (Specify) Major Road / Highway nterstate 95 at Mile Marker 81.5, Aberdeen, MD Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 📝 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 19, 2006 m.0 30 Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene Registrar Amend Item #20b Per FH g854 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Raymond Edward Smith Month Year APRIL 17,2006 10:30A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Baltimore Towson 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) MD **Funeral** 1 M 2□ F Director 215-24-3682 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or then "natural", or items 23s or 28s-f show the Medical Examiner must be notified at N/ABaltimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 305 E Joppa Road Apt # 502 21286 USA deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 72 hours after 1 XNever Married 2 ☐ Married 1 Yes 2 | 1 | / / / 1 9 | 56 | Year or Dates: -1 | 6 | 1 9 | 56 | Baltimore, Maryland 21215-0036 þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e filed within 7 al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Assistant Telephone Social Security 2yrs Specialist Administration 18. Mother's Name (First, Middle, Madden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any lighty or other traumatic event, size. 17. Father's Name (First, Middle, Last) Be Mary Elizabeth Frazier Alexander Smith 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Smith / Sister 6225 York Rd Apt # E210 Baltimore MD 21212 20b. Place of Disposition (Name of cometery, crematery) crematery or care the complete of the 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 4/25/06 Owingsmills MD Garrison Forst VA 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature Funeral Service Libensee 5240 Reisterstown Rd Baltimore MD 21215 23a Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) PNEUMONITIS INTERSTITIAL /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of). attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.O. P 9 9☐ Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à METASTATIC PROSTATE CANCER 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autonsy performed? 1 Yes 2 No 1 Yes Hospital or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 ER/Outpatient 3 DOA (his After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28d. Describe how injury occurred t Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: 3 ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours efter of Funeral Direct determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Function (Check only one) within 2 29b. Signature and title of certifier 29c. License number 9 29d. Date signed (Month, Day, Year) 06 D 37214 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) OSLER DRIVE TOWSON MARYLAND 21204 32. Registrar's Signature State APR 2 1 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year PM **Physician** SESAY 1O 200h BOBOSON MANI /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner SILVER SPRING
If Under 14 Hrs. 8. Date of Birth
Months Days Hours Mig. (Month, Day, MONTGOMERY HOSPITAL HOLY CROSS Year)
9. Birthplace (State or Foreign Country)
2006 MARYLAND 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months 1 □ M 2 💢 F Yrs. Director none Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10a State 10b. County 28a-f ahow r than "natural", or Itama 23a or 28a-f ahov The Madical Extrainer must be notified at 1 Yes 2 No SPRING SILVER Directo MONTGOMERY 10g. Citizen of What Country? 10f. Zio Code 10e Street and Number 20904 USA 3325 TEAGARDEN CR APTZOI Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Bfack, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 KNo Specify: Baltimore, Maryland 21215-0036 Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygiann important: If itam 27 is marked other training any injury or other traumatic avant. Ital 2006. none none none 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be UMAR S SESAY ISATU MANSARAY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1500 FOREST GLEN RD SILVER SPRING MD 20910 HOLY CROSS HOSPITAL 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 NOther (Specify) in state 3 tare Marconfy Board 655 W. Baltimore Street 21. Signature of Runeral Service Licensee Ronald S. Wade, Director Mal 21201 Baltimore, MD mon Approximate Interval Between Onset and Death Part 1. Inter the diseas of or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Caure (Final disease or condition resulting in death) PREMATURIT Physician /Medical Due to (or as a consequence of): Examiner PREVIABLE FETUS 20 WEEKS Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner thet the daath certificate be executed physicien end the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical or use as the IF FEMALE: 23c. ff yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) ed by tha 9 Unknown 9 Unknown s been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown BREECH 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an pege 2 s certificate hes 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical examiner? director 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 📉 No 1 Inpatient ၉ this 28a Date of fnjury (Month, Day Year) 28c. Injury at Work? funeral 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification; After or Attanding 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No deeth. investigation To the Hospitel or Attandi within 24 hours after deeth To the Funeral Director: A completely filled in by the ft 2 Accident 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 2006 111 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SPRING MD 20910 1400 FOREST GLEN RD SILVER RAFIQ CM MIAN 32. Registrar's Signature 31. Date filed (Month, Day, Year) APR 2 1 2006 COS ASSES State Se Spelan Registrar

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	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Ye	
	/Medic	- 11	John Albert Stanle 4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Dea	April 15	4c. County of D	2:27 PM M
	Examin	lei	Holy Cross Hospita			Silver			Montgo	
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. la:		If Under 1 Year Months Days	If Under 24 Hr Hours Min	. (Month, Day,	Year)	Birthplace (State or Foreign Country)
	Director		172-12-0792 Usual Residence of Decedent	87	Yrs.			June 25	, 1918 P	ennsylvania
	ryland		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	Ba-f e	cto	MD Montgome	ry W	heato					1 ☐ Yes 2 No
	with the	Dire	10e. Street and Number 3411 Pendleton Dr	ive		10f. Zip Code	0902	10	ng. Citizen of What USA	Country?
	death	Funeral Director		12. Was Decedent Ever in U.S.	. 13. V			Specify Yes or No- rto Rican, etc.)	14. Race - A	merican Indian,
36	within 72 hours after death with the Maryland ene. than "natural", or iteme 23a or 28a-f ehow tha Madical Examiner must be notified a	y Fui	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give		Yes, specify Cubar	n, мехісап, Рие Specify:	no Hican, etc.)	Black, W Specify: W	/hite, etc.
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2	filed with Hygiene other the	Com	12	4	pr	inter/pub	lisher			
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<u>s</u>	end 2 s eelth an n 27 Is er trau		Don Stanley/son	20, 1 1111	TOD: INIZINIT	g Add1633 (517661 &	no rember or r	unai riodie ivalidei,	City of Town, State	e, Zip Code)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelin and Mently Hygiene. Department of Heelin and Mently Hygiene. The most set a show mortant: If term 27 is marked other than "natural; or iteme 23a or 28a-1 show any injury or other traumatic event, tra Madical Examinat must be notified at once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R. 4 ☑ Donation 5 □ Other (Specify)	con	ce of Dispos metery, crem	sition (Name of natory or other place	9)	Date 2	20c. Location - City	or Town, State
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	\$	Ì	30. Name and address of person who con	mpleted cause of death (Item 2	(Type, F	Print)	11/201	V . A	- 🗼	3 0 - 0
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	DOM re	on a	www	ninglo	n, D	- 20010
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			State of Maryland / Dep		Mental Hy	400	6 12548
			Registrar Amend Item #10b-f Per FH G854	4/21/06 Jif	2. Date of De	Reg. No.	3. Time of Death
	Physic /Medi		GENEVIEVE B. SCHWARTZHAUPT		APR.	19, Day 2006	10:00 A ^M
	Examir	ner	4a. Facility Name (If not institution, give street and number) IVY HALL NURSING CENTER	4b. City, Town, or Location of Death MIDDLE RIVER		4c. County BALT	of Death IMORE
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 218-05-4965 1 M 2 T F 95 Yrs.	Months Days Hours Min.	8. Date of Bir (Month, Da SEPT.	o, 1910	Birthplace (State or Foreig Country) MD .
	land ow		Usual Residence of Decedent 10a. State 10b. County Baltimore 10c. City, Town or	ocation			10d. Inside City Limits
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	or 28	Olrec	10e. Street and Number	10f. Zip Code		10g. Citizen of V	Vhat Country?
	ath w	rai	155 S. GRUNDY ST. 1604 Cape May RD.	21224		UNITED	STATES
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deportment of Health and Mental Hygiene. Intercreant: if Item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, I'm Medical Evaculi or must be ricitlied at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give A Year or Dates:	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🛣 No Specify:	pecify Yes or No Rican, etc.)	14. Race Blac Specify	e - American Indian, k, White, etc. : WHITE
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Baltimore,	permit. Depart Import		21. Signature of Funeral Service Licensee	2. Name and Address of Facility CF 6224 EASTERN AVE.,	ARLES S	S. ZEILER	R & SON. INC.
Ī			23a. Part Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
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K	be executed sicien and burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
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8760,	cate phy:	dicai	d				
.O. Box 6	The law requires that the death certific Ite has been signed by the attending p page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 4 □ Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date Mon	o of delivery th Day Year
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VIE	Physician: this certificated that	Be	25. Was case referred to medical examiner?	26. Place of Death			
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o D	Attending in death.	ation	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation 28a. Date of Injury (Month, Day Year) Injury	f 28c. Injury at Work? M 1 Yes 2 No	200. 00301100 1	iow injury occurre	
Division	al or Attendi s after death. il Director: A id in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)	reet, factory, office	28f. Location (S City or Tox	Street and Number vn, State)	r or Rural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the ded at the time, d	cause(s) and man date and place, ar	ner as stated. nd due to the cause(s)
•		X	29b. Signature and title of certifier M-D.	29c. License number D-38-75	7 4		(Month, Day, Year) 20-2006
	3		30. Name and address of person who completed cause of death (Item 23a) (Type MALIKA WASBEM. 709	Print) BASTERN	BLVP	. MD	1-21221
	Sta Registra		31. Date filed (Month, Day, Year) APR 2 1 2006 32. registrar's Signature	enter			

DHMH 17 Rev 1/2001

				For State Registrar			/ Depa	artment of tificate of	Health a		ental Hyg		•	12549
			.*	Decedent's Name (First, Middle, Last)						2. Date of Dea Month		V	3. Time of Death
_		Physicia Medic/		Luticha Belle Ste	phenson						April	19	2006	6:48 a.m.
		Examin		4a. Facility Name (If not institution, give	street and numb	ber)		4b. City, Town,	, or Location of	Death			County of Death	1
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		uneral irector		236-22-4878	х]м 2[X]F	. Age (In yrs. /as	Yrs.	Months Day		Min.	B. Date of Birtl (Month, Day May 9,	192	Wes	place (State or Foreign intry) t Virginia
	and	A. T		Usual Residence of Decedent 10a, State 10b, County		10c. City,	Town or Lo	cation					T	10d. Inside City Limits
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1.484n	d 21215-0036 filled within 72 hours after death with the Maryland Housiene	rthan "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Deced Armed Ford 1 Tes 2 If Yes, Give	. X No	1	Was Decedent of I Yes, specify Cu		jin? (Spec , Puerto R	offy Yes or No- lican, etc.)		4 Race - Amer Black, White Specify: W	
13	Maryland 21215-0036 at 2 should be filed within 72 hours aften and Mental Hydiene.	aturai', cal Exp	ted by	3 ₩ Widowed 4 □ Divorced 15. Decedent's Edu	Year or Dat	es:	16a. Dece	dent's Usual Occ	cupation	of under			d of Business/I	ndustry
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13	aryland service services	p >	To Be	Samuel H. Butcher	•						Sharp			4.2.
61		item 27 is marke other traumatic		19a. Informant's Name/Relationship (T		nter		ng Address (Stre Haselme					Town, State, Z 21222	ip Code)
4	o se to			20a. Method of Disposition 1	Removal from S		dens	osition (Name of matory or other p of Fait	h ()4 - 21		Balt:	ation - City or l	MD
	Baltimo	any inj		21. Signature of Funeral Service Licens	2			2. Name and Add			-	-		Home, Inc.
<	0.79 08			23a. Part 1 Enter the disease, or comp shock or heart failure. List only of	fisations that ca	used the death.	Do not ent	er the mode of d	lying, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between
0	Phy	sician		Immediate Cause (Final disease or condition			art	en dis	case				10 A	Onset and Death
S		ledical iminer		resulting in death)		r as a conseque		7						
_	*	-	٦.	Sequentially list conditions,	b. Due to (c	or tic	STEN	10515						unkhown
<	W 3	nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	240 10 10									
W	760, A	sician and burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (c	r as a conseque	nce of):							
OH O	760,	2 0 1	cai	(d									
1/1	68 riffical	as th	ledi	IS SEVAN S.										
576	Vital Records, P.O. Box 68 sicien: The law requires that the death certifical	mining the formulation of the formulation of the second signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	Physician/Medi	in the past 12 months?	1 Live bir	ome of pregnand th 2 Fetal o int at time of dea	leath 3[Ectopic pregnal Other (specify)				2	3d. Date of deli Month	very Day Year
·	P.C	d by the	Phy	9 ☐ Unknown Part II. Other significant conditions co	entabuting to de-	ath but not recult	ing in the u	nderbring cause	gwen in Part I		23e Did to	obacco us	se contribute to	the cause of death?
A	ds,	signe d be d	t by	Part II. Other significant conditions of	antilodting to det	atti bat not ibsan	ang in the d	riderlying dadse	givoir ii i acci.				No 3□Pro	
#	S Per	shoul	etec								24a. Was	an	24h Were au	topsy findings available
0	Reconstruction of the same of	ge 2	Completed								autop perfo	rmed?_	prior to death?	completion of cause of
-	ta ::	ificate or, pa	e Co	25. Was case referred to medical					26 Place	of Death	1 ☐ Yes (Check only o		1 L Yes	2□ No
1	Veicie	Scert	To B	avaminar?	Hospital:	patient 2 E	R/Outpatie	nt 3 DOA	Othor		2/		Other (Spec	cify)
	of Phy	er this		27. Manner of Death	28a, Date o		28b. Time a	1 28c, Ir	njury at Vork?		8d. Describe I			,
3	indin di	r: Aft	atlo	1 Natural 5 Pending 2 Accident investigation		, Day Tear)	injury		Yes 2 1	No				
7	Division of	i Directo	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	286. Place	of Injury - At horn g, etc. (Specify)	ne, farm, st	reet, factory, offic	08	2	8f. Location (S City or Tov	Street and vn, State)	Number or Ru	ral Route Number,
	• Hospita	e Funera	Medical C	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Exam	ysician: To the iner: On the ba and mann	sis of examination	ledge, deat on and/or in	h occurred at the	time, date and by opinion, deat	d place, a th occurre	nd due to the	cause(s) date and	and manner as place, and due	stated. to the cause(s)
_	To th	To th	Ψ	29b. Signature and title of certifier				29c. Lice	ense number			29d. Date	signed (Mont!	n, Day, Year)
				2/80 MD					12417	0		Apr.	1 19,2	doop
		1.		30. Name and address of person who	ompleted cause	of death (Item :	23а) (Туре,	Print)	2 11.		142		•	
		4		31. Date filed (Month, Day, Year)	tospice	838 N Maistrar's Signatu	tuit	(wst	Baltin	neve,	MUD !	2120) [
		Sta Registr		ÅDD 9 1	anne 32. n	and a digitally	N /	mets)						
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ORIGINAL

			1 - For State Registrar	State of Marylar		artment of tificate o		and Men	tal Hygie	2000	12550
	\$		Decedent's Name (First, Middle, Last)						Date of Death		3. Time of Death
	Physici		Justice Tho	mas Tille	maa				Month	S 2006	2309 PM
No.	/Medic Examin	_	4a. Facility Name (If not institution, give s.	reet and number)	11017	4b. City, Town	, or Location o		2-1 10	4c. County of Deatl	
	Examin	er		e Medical C	· A Far	Rall	\(\) - : \(\)			22 = H	7
	Consent		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Ye	ar If Under 2	24 Hrs. 8. [Date of Birth	9. Birth	place (State or Foreign
	Funeral Director		N/A 15	M 2□F	Yrs.	Months Day	s Hours	Min. Ap	Date of Birth Month, Day, Ye	2006 Ma	aryland
			Usual Residence of Decedent								
	ylan		10a. State 10b. County	10c. Ci	ty, Town or Lo		imore				10d. Inside City Limits
	Mar Med	tor	Md. N/A			рат	THOTE				1 ☐ Yes 2 ☐ No
	h the	Director	10e. Street and Number			10f. Zip Code			10g.	Citizen of What Co	untry?
	th will	at	1 Norham Court			1	21221			U.S.A.	
	dea	Funeral	11. Marital Status	Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of f Yes, specify C	f Hispanic Orig	gin? (Specify	Yes or No-	14. Race - Amer Black, White	
ထွ	or its	Fu	12⊈ Never Married 2 Married	1 ☐ Yes 2 No ff Yes, Give		1 □ Yes 2 💁 N		.,	., 5.6.,		
8	filed within 72 hours after death with the Maryland Hygiene. Iffer then "naturel", or items 23a or 28a-f ehow ent, the Macifel Examiner must be notified a	d by	3 Widowed 4 Divorced	Year or Dates:			o opcony.			Specify: bi-	-racial
, L	72 h	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occ kind of work do	ne during most	t of working	16b	b. Kind of Business/l	ndustry
2	ulthin	mpi	Elementary/Secondary (0-12)	Coffege (1-4or 5+)	life. I	DO NOT use ret					
2	filed v Hygie other ti		N/A 17. Father's Name (First, Middle, Last)			depende		1- 1 (5)	. 14:44-14	N/A	
Ë	e d a b	Be							st, Middle, Maid	den Sumame)	
<u> </u>	should be filed within 72 hours after death with the Marylan and Mental Hygiene. **Branked other then "naturel", or items 23a or 28a-f show umatic event, the Marolcal Examinar must be couldied at	To	Truth Tillman					ifer L			
Maryland 21215-0036	2 2 2	1	19a. Informant's Name/Relationship (Type Jennifer Langle			ng Address <i>(Stre</i> Orham Co				ity or Town, State, Z	ip Code)
	1 and 2 Health tem 27 other tr		20a. Method of Disposition			sition (Name of	Jule, D	Date		. Location - City or	Town State
ō	Pages intention of the		1 Burial 2 □ Cremation 3 □ Re	moval from State	cemetery, crer	natory or other p e Baptis	olace)	Date	200	. Location - City or	rown, State
<u>E</u>	tant:		4 □ Donation 5 □ Other (Specify)	Ch	urch C	emetery		4/20/2	006E	Bel Air. N	/d.
Baltimore,	permit. Pag Depertment Important: eny injury o		21. Signature of Funeral Service License	•	22	. Name and Add Schimune	dress of Facility Results Re	ral Ho	me of E	Bel Air, I	Inc.
	20 = 0		Jan De	5		610 W. 1	MacPhai	1 Road	, Bel A	ir, Md.	21014
			23a Fart1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the dea e cause on each line.	th. Do not ent	er the mode of o	lying, such as	cardiac or res	piratory arrest,		Approximate Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition	Extreme	Pren	naturi	tu				Oriset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec							
	LAditiliei		Sequentially list conditions, b.								
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	ecute and -trans	Examiner	that initiated events resulting in death) Last	D							
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8/60	the death certificate be executed y the attending physicien and sched for use as the burial-transit	dical	d			·					
×	eath certific attending p	Me	fF FEMALE:	4						THE DESIGNATION OF THE PERSON	
Вох	ath c	Physician/Me	23b. Was decedent pregnant in the past 12 months?	lc. ff yes, outcome of pregn 1☐Live birth 2☐Feta	aldeath 3	Ectopic pregna				23d. Date of deli	very Day Year
- 0	at the de by the a teched f	/slc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of o	deafh 5∟	Other (specify)					,
Ţ.	thet the	F	Part II. Other significant conditions con	whyting to death but not re-	culting in the u	ndarhina causa	awan in Part I		23e Did tobace	co use contribute to	the cause of death?
Š,	80 00	þ	Tarris, other significant conditions con	mouning to death out not les	salang in ale a	idenying cause	given in raiti.		1 ☐ Yes		obably 4 Unknown
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Records,	e law hes b	ğ							24a. Was an autopsy	24b. Were au prior to d	topsy findings available completion of cause of
		Completed							performéd 1∐ Yes 2∭X	1? death? No 1 ☐ Yes	2 No
Vital	sician: certifica rector, p	Be	25. Was case referred to medical examiner?			-		of Death Ch	eck only one)		
=	Physic this c	၉	1 105 22 100		ER/Outpatier	3 DOA				e 6 □Other (Spec	cify)
Ē	ding P	on:	27. Manner of Death 1 Natural 5 Pending	28a. Date of fnjury (Month, Day Year)	28b. Time of Injury	V			Describe how i	n _f ury occurred	
Division of	uttendi death. ctor: A ctor: A	cati	2 Accident investigation 3 Suicide 6 Could not be		<u> </u>		☐ Yes 2☐!				
≥	at or Attend after death f Director: / d in by the f	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	iome, farm, str <i>fy)</i>	eet, factory, offic	ЭӨ	28f. l	Location (Stree City or Town, S	t and Number or Ru tate)	ral Route Number,
_	pital ours a srei [200 Contition					<u></u>			
	To the Hospital or Attending Physician: within 24 hours after death and 17 to the Funeral Director: After this certific completely filled in by the funeral director.	Medicai	29a. Certifier (Check only one) Certifying Phys Certifying Phys Check only one)	ician: To the best of my known on the basis of examinating	owledge, deati ation and/or in	n occurred at the vestigation, in m	ume, date and y opinion, deal	d place, and o th occurred at	the time, date	e(s) and manner as and place, and due	stated, to the cause(s)
	ithin (Mec	29b. Signature and title of conflier	and manner stated.		29c. 1 ice	ense number		294	Date signed (Mont)	1. Day. Year)
1	F 3 F 8			1				11			
h				CASES	7	100	0328	7.		2/19/14	000
1			30. Name and address of percon who con	- 1	m 23a) (Type,	Print)	m 1			010	000 ic,mp
			31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature CMC	scipeciti	5 11169	Ticel (64216	, Del H	1,c + 11111.
	Sta	IC.	APR 2 1 2006	61	1 A	D 0					

			For State	State of Marylan	d / Departn		lealth and N	lental Hy	giene	6 12551
	Physici	an	1. Decedent's Name (First, Middle, Last) Marion Tollive	er Jr.	Oeran	cate or	Death	2. Date of Dea	ath Day 20	3. Time of Death
9	/Medic Examin	er	4a. Facility Name (If not institution, give str MARY/AND GENER 5. Social Security Number 6. Sex	1 1/-0	ast birthday) If I	Joder 1 Year	r Location of Death ORL If Under 24 Hrs.	Coffy 8. Date of Birt	4c. County of	N/A
	Funeral Director			M 2□F 86	Yrs. Mo	nths Days	Hours Min.	May 2	2 ^(*) 919	Country) MD
١	e Marylan ta-f ehow	ctor	10a. State 10b. County MD	N/A		imore	<u> </u>			10d. Inside City Limits 1 Yes 2 No
R	th with th	ai Dire	10e. Street and Number 1505 Druid Hill			Of. Zip Code	21217		10g. Citizen of Wh	USA
5-0036 5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if Items 23a or 28a-f show important: if Items 27 is marked ofther than "neturel", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Evant arrival be notified at once.	by Funeral Director	11. Marital Status 1. Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 ★ No If Yes, Give Year or Dates:		Decedent of H s, specify Cuba Yes 2∯ No	dispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Black,	- American Indian, White, etc. Black
	within 72 ho ene. then "netur he Medical	Be Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12) 1 2 t h	ation completed) College (1-4or 5+)		s Usual Occup of work done NOT use retired	during most of world)	sing	16b. Kind of Busi	iness/industry 1 Government
Baltimore, Maryland 2121	uld be filed Aental Hygi rked other tic event, I	To Be C	17. Father's Name (First, Middle, Last) Marion Tollive	er Sr.			Blanch	e Gray	Maiden Sumame)	
Mary	nd 2 shoualth and N 27 le mai		19a. Informant's Name/Relationship (Type Eula Anderson /		19b. Mailing Ad 1505 I	ddress <i>(Street</i> Druid	and Number or Ru Hill Av	ral Route Numbe e Balt	imore M	tate, Zip Code) D 21217
$/\mathcal{O}_{\mathcal{K}}$ more,	Pages 1 a lent of Hea nt: If Item ry or otha		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	omoval from State New	Place of Disposition cometery, crematory Catheoutery	n (Name of ry or other pla dral (ce) Cem. 4/	Date 22/06		more MD
Balti	permit. Depertm Imports eny inju		21. Signature of Fineral Service License	l sin						Funeral Home re MD 21215
3760,	La be executed by the control of the	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a)	arluke pence of): AC H	rt P.	arluke 18/3			Interval Between Onset and Death
Division of Vital Records, P.O. Box 68	Physician: The law requires that the death certificate this certificete hes been signed by the attending phyrati director, page 2 should be detached for use as the	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Bc. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o 9 ☐ Unknown	al death 3 □Ect	opic pregnanc ner (specify) _	y III		23d. Date Mont	of delivery th Day Year
ords, P.	w requires that t been signed by should be detad	ted by Ph	Part II Other significant conditions con Encephalopo	tributing to death but not res	Sulting in the under	tying cause gr	ven in Part I.	10	Yes 2□No 3	oute to the cause of death? ☐ Probably 4 Unknown
al Rec	yslcian: The law r is certificete hes b director, page 2 sh						G0 Slave 4 Doc	1 ☐ Yes	ormed? de 2. No 1.	ere autopsy findings available for to completion of cause of sath? Yes 212 No
fVit	Physiciar this certif al directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 I npatient 2	ER/Outpatient	3 LUCA		ome 5□Res	dence 6 Other	
o nois	To the Hospitel or Attending Ph within 24 hours efter death. To the Funeral Director: After thi completely filled in by the funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)]Yes 2 □No		how injury occurred	
Divis	itel or Att rs efter de al Directo led in by t	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ify) 			City or To	wn, State)	r or Rural Route Number,
	ne Hospitel 124 hours e ne Funeral I	Medical		sician: To the best of my kn ner: On the basis of examination and manner stated.						
	To the within 2 To the complete	Me	29b. Signature and title of certifier	WACHUKWU	MD	29c. Licen	se number 9 549		29d. Date signed	(Month, Day, Year)
•	11		30. Name and address of person who co		IAULIU)//ER	jand	Genera	al Hoz	pital
	St Regist	ate trar	31. Date filed (Month, Day, Year) APR 2 1 2	32. Registrar's Sign	ature Ap	antis	J			

Physician /Medical Box 68760. P.O. Division of Vital Records,

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit signed I funeral director. his within 24 hours after death. To the Funeral Director: A filled in by ë ë

Physician

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Infortant: If tiem 27 is marked other than "naturel", or items 23s or: propriatory or other traumatic event, the Medical Examinational Lengus. 2008.

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Be Completed 25. Was case referred to medical examiner? Certification: To 27. Manner of Death 1 (I) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 (I) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) RES OOD MD APRIL 14, 200 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 SOUTH HANDVER ST BALTIMORE, MD 21225 LAY KITIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature ate 2006 DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2553 For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) April 2006 **Physician** 7:06 P M Michael Thomas Woodring /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Silver Spring 16 Eastmoor Dr. If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours 12XM 2□ F 64 Yrs. Dec. 23, 1941 Pennsylvania Director 182-34-6561 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State the Missigal Exempler must be notified at 1 Yes XXNo Silver Spring Director Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20901 United States 16 Eastmoor Dr. or iteme 23a Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1961-63 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) Radio Traffic Manager Communication marked other 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: if Item 27 is marked other any injury or other traumatic event 17. Father's Name (First, Middle, Last) Rosencranz Mae Woodring Marion Car1 Joseph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 Eastmoor Dr., Silver Spring, MD 20910 Donald C. Schimmel / Partner 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Chesapeake Crematory 4/19/06 Beltsville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Rapp Funeral & Cremation Services 21. Signalare of Funeral Service Licensee Still Addinasma 20910 M00382 933 Gist Ave., Silver Spring, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician of Asch /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit puq Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. physicien Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day Month Year ō in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the a detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ eq Yes 2 No 3 Probably 4 Unknown page 2 should Completed peen 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 1 ☐ Yes 2 No 26. Place of Death [Check only one] funeral director, 25. Was case referred to medical Be examiner? Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Spearly) 1 ☐ Yes 2 No မ 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: After or Attending 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: A 2 Accident the 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide filled Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely To the 29b. Signature and title of certifier

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person

31. Date filed (Month, Day, Year)

APR 2 1 2006

Baltimore, Maryland 21215-0036

2415

Mayore Rd Sute 73

cause of death (Item 23a) (Type, Print)

2. Registrar s Signature

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Anthony Walker 1. For State Certificate of Death Reg No Registrar 2. Date of Death Decedent's Name (First, Middle, Last) Time of Deat Physician/ Month Day April 13, 2006 1840 hrs Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore University Hospital 5. Social Security Number 6. **S**ex . Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYY) 9. Birthplace (State or **Funeral** Foreign Months Days Hours Director 1 X M 2 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location State Yes 2 No 28a-f show tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho: or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country Street and Numbe 10e. 14. Race - American Indian, Black Funeral 12. Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc 1 Never Married 2 Married Yes Yes 2 X No specify: f Yes, Give Year Specify Widowed Divorced \$ Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industr 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed within 72 and Mental Hygiene 21215-0036 's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last 18.Mothe Be s I and 2 should b f Health and Men 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type mother 11 Location - City or Town, State 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition Baltimore, other place) crematory or 2 Cremation 3 Removal from State 1 X Burial 200 mportant: Other Specify Donation 5 ature of Funeral Sentice Licenses Name and Address of Facility Approximate Interval ased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart een Onset and lure. List only one cause on each line /Medical Death a. Gunshot wounds (2) to torso and right arm Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last andtransit Physician/Medical UNPENDED AMENDED tending physician use as the burial Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown Unknown 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. ð Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed' Yes 2 26.Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be examiner? Nursing Home 5 ✓ Inpatient ER/Outpatient 3 Residence 6 1 🗸 Yes No ဥ 28a. Date of Injury (Month, Day Year) Apr 13, 2006 28b. Time of Injury 28c. Injury at Work? 28d, Describe how injury occurred Manner of Death Certification: Subject shot 1806 hrs 1 Yes 2 V No 5 Pending the Accident Investigation Location (Street and Number or Rural Route Number, City 28e Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide 2314 Callow Avenue, Baltimore, Md determined (Specify) Sidewalk 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started ca To the Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number O.C.M.E. April 14, 2006 30 Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. Assistant Medical Examiner 31. Date filed (Month PRY State 2006 Registrar

မှ Certification:

1 V Yes 27. Manner of Death Natural

Pending Investigation

Fnd 4/4/2006

(Specify)

Found at residence

28b. Time of Injury 28c. Injury at Work? Fnd 10:30 am

1 Yes 2 No 28e Place of Injury - At home, farm, street, factory, office building, etc.

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City Partition, State \$17 N Glover St Baltimore, 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Accident

Suicide

Homicide

2

3

Nedical

29c. License number O.C.M.E.

29d Date signed (Month, Day, Year)

Death

30 Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Theodore King MD.

2006

6 X Could not be

determined

111 Penn Street, Baltimore, MD 21201

31. Date filed (Month pray Xear) Registrar

DHMH 17 Rev 1/2001 OCME 10/2003

CULEMAN

MILSON,

Pages 1 and 2 should be filed within 72 hours after death with to nent of Health and Mental Hygiene. ant: If item 27 is markad othar than *natural", or Itams 23a or 2

Department of Health a Important: If itam 27 Is any injury or othar trat once.

Pnysician

Examiner

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

/Medical

burial-transit

use as the

page 2

filled in by the funeral

After

safter death.

within 24 hours after To tha Funeral Dira

To the Hospital

Examiner

Physician/Medical

Completed by

Be

2

Certification:

Medical

Baltimore, Maryland 21215-0036

006

4c. County of Death

3. Time of Death

1125AM

11 Yes 2 No

State of Maryland / Department of Health and	Mental Hygiene	1255
Certificate of Death	Reg. No.	1600

cation of Death

			1 - State Registrar						Cei	tifica	te of L)
	Physici /Medic		1. Decedent's Na	me (First, Midd	de, La		mar	ı Lee	Wilso	n. S	r	
	Examir		4a. Facility Name		-		mber)		WIIDO		, Town, or	L
	Funeral Director		5. Social Security 228-42- Usuel Residence	6669	6. 5	ex I⊠M 2□F	7. Age	73	t birthday) Yrs.	If Unde Months	Days	-
	the Maryland 28a-f show polified at	tor	10a. State	10b. Count	y /A			10c. City, Ba	Town or Lo	cation		_
	th with the M. 23a or 28a-f	al Director	10e. Street and N 2518		yet	te Ave	nue			10f. Zij	p Code	_
036	d 2 should be filled within 72 hours after death with the Maryland th and Mental Hygiene. The markad othar than "natural", or Itams 23a or 28a-f show traumatic avant, Ita Madical Examiner must be notified at	by Funeral		rried 2 <mark>∑</mark> Ma 4 □ Divorce		12. Was Dec Armed For 1 17 Yes If Yes, Gi Year or D	orces? 2 □ N		1 1	Was Dece f Yes, spe l ☐ Yes	dent of His ecify Cubar 200 No	ip
15-0	n 72 hc	leted	(Sp	15. Decede ecify only high		ducation ade completed)			16a. Deced	kind of wo	ork done di	ur
212	be filed within tal Hygiene. Id other than avent, Inc. M	Completed	Elementary/Se			College (·		He1p	ise retired) er	
Maryland 21215-0036	uld be file fental Hy rkad othe tic avant,	To Be C	17. Father's Nam Isiaih	e (First, Middle								18
Mary	d 2 should th and Mer 7 Is marks traumatic		19a. Informant's			**			19b. Mailin	-	s (Street a	

N/A f Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Min. 1-29-1933 Va 10d. Inside City Limits

2. Date of Death

Month

10g. Citizen of What Country? 10f. Zip Code 21216 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No Specify: Specify: Black

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Helper Bethlehem Steel

18. Mother's Name (First, Middle, Maiden Sumame)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Nannie Richarson

Ruth Wilson - Wife 20a Method of Disposition

2518 W. Lafayette Avenue Balto, Md 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State

1√ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun par Sorvice Licensee

Garrison Forest Vet | 4-25-2006 22. Name and Address of Facility

Owings Mills, Md March F/H West

4300 Wabash Avenue Balto, Md 21215

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

ANOXIC Due to (or as a consequence of): END STAGE RENAL DISEASE

Due to (or as a consequence of). INIRA CRANIAL

Due to (or as a consequence of):

DEPENDENT

resulting in death) Last

that initiated events

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4☐Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

ENCEPHALOPATHY

23d. Date of delivery Month Dav

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hospital:

9 Unknown

DIJURDER

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Hriknown

24a. Was an autopsy performed? 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

3/21No 26. Place of Death (Check only one)

BATTINONE NO

25. Was case referred to medical examiner? 1 Yes 2 No

(A) ZURE

27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 6 Could not be determined 3 Suicide

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

fU.TE

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

34

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

4 Homicide

29a. Certifier

ATTENDING

29c. License number 20056948 29d. Date signed (Month. Day, Year) 18

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAMO 300 ARMONT PLACE TANDINDA MD

State Registrar 31. Date filed (Month, Day, Year) APR 2 1 2006



State of Maryland / Department of Health and Mental Hygiene 🖺 🖺 🖺 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Lauren Dimler Wexler 2:30 P April 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Towson

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Baltimore Greater Baltimore Medical Center 8. Date of Birth
(Month, Day, Year)
AUG • 11,1954 Birthplace (State or Foreign Country)
 New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🂢 F Months 51 262-15-2243 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10a State 10h County 28e-f show ir then "natural", or iteme 23a or 28e-f show the Maylcal Examinar must be notified at Maryland Baltimore County Lutherville 1 ☐ Yes 2 No Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21093 65 Arverne Court United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes ŽŒNo Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

| Compared to the second comp 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Home Maker Own Home N/A other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) is marked Raymond Dimler Eleanor Martins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Sylvan Wexler (Husband) 65 Arverne Court, Lutherville Maryland, 21093 27 Item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ortant: If it 1 ☐ Burial 2XD Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Evans Funeral Chapel Apr. 20,2006 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr. P.A. 21. Signature of Funeral Service Licensee 2325 York Road Timonium, Maryland 21093 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a conse Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐Ño Month Year Day 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ sign 1 be 3 Probably 4 □Unknown 1 □ Yes been si Completed 24a. Was an autopsy performed 1 Yes 2 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has t irector, page 2 s or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 2 ER/Outpatient 3□ DOA this After thi 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification; Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide hours after in 24 hour,
of the Funeral Drophetely filler 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintain as secured at the time, date and place, and due to the cause(s) Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mapner stated. Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica (Check only one) 29b. Signature and the of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OWS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

Wexer, Lauren

			For 1_ State	State of Marylan	d / Department of H		d Hygień	e006	12558
			Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of L		Reg. Note of Death	0.	3. Time of Death
	Physici /Media		Isabel	m.	Weston	AMO	onth D	2000 Year	9:25 AM
	Examir Funeral Director	ier	4a. Facility Name (If not institution, give s 5. Social Security Number 7. 7. 7. 7. 7. 7. 7. 7. 1.	ows Norsin	atome Gle	If Under 24 Hrs. Hours Min. (Mc	e of Birth	County of Deat Da / 9. Birt	hplace (State or Foreign
	D		Usual Residence of Decedent	100 610	. Town or I continu		11,11	10-1100	10d. Inside City Limits
	a-f show	ctor	10a. State 10b. County	nore G	y, Town or Location AVM				1 Yes 2 No
	h with the	al Dire	10e. Street and Number	rm rd Ap	12.7 10f. Zip Code	057	10g. C	itizen of What Co	ountry?
936	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Modical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	.S. 13. Was Decedent of Hi If Yes, specify Cubar 1 \(\text{Yes} \) 2 \(\text{No} \) No	spanic Origin? (Specify Yen, Mexican, Puerto Rican, Specify:	es or No- etc.)	14. Race - Ame Black, White Specify:	
215-0036	72 ho	eted	15. Decedent's Edu (Specify only highest grade		16a. Decedent's Usual Occupa (Give kind of work done d	lurina most of workina	16b. I	Kind of Business/	Industry
2121	ad within /giene. ar than t, it e Ma	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	Telegraph	OPErato	r w	lesterr	1 Union
Maryland	should be filed ind Menta! Hygi s marked othar umatic event, I	To Be	17. Father's Name (First, Middle, Last)	Weston		18. Mother's Name (First,	Middle, Maide.	n Sumame) KD 15:	se
Mary	id 2 sho Ith and I 27 is ma traums		19a. Informant's Name/Relationship (Ty	DO, Print) (Nephew)	19b. Mailing Address (Street a	and Number or Rural Route	Number, City	or Town, State, 2	Zip Code) 21084
ore,	permit. Pages 1 and Department of Health Important; If itam 27 any injury or other tr once.		20a. Method of Disposition 1 Ø Burial 2 □ Cremation 3 □ R	,	Place of Disposition (Name of semetery, crematory or other place	Date Date	20c. l	_ocation - City or	Town, State
Baltimore,	t. Partmer		' 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Incense) M	Orcland Par 22. Name and Addres	s Eschaps Fr	26 10	2 / KOIII	GMD 1
Ä	permi Depar Impor any ir		the the	-	8800 Ha	ford rd Pa	arkoi	ille, m	
	Physician		23a. Part1. Enter the disease, or a mali shock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)	e cause on each line.	h. Do not enter the mode of dying	FAILUR	atory arrest,	- 55	Approximate Interval Between Onset and Death 7 DHYS
	/Medical Examiner		ſ	Due to (or as a conseq	uence of): - FIBRILLY	ATTON			ZPAGF
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq		RY DISE	AS6		FYEARS
8760,	icate be executed physician and s the burial-transit	dicai Exa	resulting in death) Last	Due to (or as a conseq	neuce of): NSION				30 YEARS
Box 68	The law requires that the death certifica tite has been signed by the attending phroage 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₺ No	3c. If yes, outcome of pregnation 1 Live birth 2 Feta	I death 3 Ectopic pregnancy			23d. Date of deli Month	ivery Day Year
P.0	d by the	Phys	9 ☐ Unknown Part II, Other significant conditions con	9 Unknown	ulting in the underlying cause and	on in Part I 23	e Did tobacco	use contribute to	the cause of death?
	w requires tha been signed i should be det	ed by	Partin Other Significant Conditions Con	minuting to death out not res	uning in the underlying cause give		1 Yes 2		obably 4 Unknown
I Records,	sician: The law requ certificate has been irector, page 2 shoule	Completed					a. Was an autopsy performed?] Yes 2 🔯 N	prior to death?	Itopsy findings available completion of cause of 2 \(\text{No} \)
Vital	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	ospital:	58/0 total all soal Othe	26. Place of Death (Chec	A STATE OF THE PARTY OF THE PAR		
of	ding Phy T. After this funeral d	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Jnjury Work	at 28d. De	Residence		cify)
Division	f or Attending after death, Diractor: Afte I in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, factory, office	28f. Loc City	cation (Street a y or Town, Stat	nd Number or Ru 'e)	iral Route Number,
	To the Hospital or Attend within 24 hours after death to the Funaral Diractor: completely filled in by the	Medical Co			wledge, death occurred at the tim tion and/or investigation, in my op				
	To the within ;	Me	29b. Signature and title of certifier	Δ.	29c. License			ate signed (Month	
	2		RAN	HANA GOPPIA	NMP D57:	228		4/17/2	2006
1	7		30. Name and address of person who con RAM BN A GOP K 31. Date filed (Month, Day, Year) APR 2 1 20	mpleted cause of death (Item	23a) (Type, Print) ROLLING	CROSSRO	HO COG	59 BAC	71m025 1228
F	Sta Registi		31. Date filed (Month, Day, Year) APR 2 1 20	32. Registrar's Signa	the posts			•	

			For State Registrar	State of Ma		epartmen Certificat			d Meni		iene	006	12559
· > 2	er i a		1. Decedent's Name (First, Middle, Las	(1)						ate of Deat	h Day	Year	3. Time of Death
	Physici /Medic		Lillian	E1	izabeth		We	idner	Apı		19	2006	10:00 P M
	Examin	- 2	4a. Facility Name (If not institution, give	00 5	. (4 -	4b. City.	Town, or L	ocation of De	eath	n d	4c. C	ounty of Death	-
				ces, 33 D	(In yrs. last birt	hday) If Under	1 Year	If Under 24 H	Hrs. A D	ate of Birth		CCC.	place (State or Foreign
	Funeral Director			M 2□F		rs. Months	Days		fin. (/	onth, Day,	Year)	Cou	ryland
1	70		Usual Residence of Decedent	21					,,,,,				
	rylan		10a. State 10b. County		10c. City, Town	or Location							10d. Inside City Limits
	Ba-1 e	cto	Maryland Cecil		North								1 Yes 2 No
	vith th	Dire	10e. Street and Number			10f. Zip				1		en of What Cou	intry?
	e 23	erai	33 Dr. Carr Road	12. Was Decedent B	ever in U.S.	13. Was Dece	L901	panic Origin?	(Specify	Yes or No-		U.S.A.	ican Indian,
	tter d	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🖾 N		If Yes, spe	offy Cuban	, Mexican, Pu	ierto Ricar	n, etc.)		Black, White	, etc.
036	urs a	by	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2 <u>k</u> No	Specify:			5	Specify: Wh	ite
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or iteme 23a or 28a-f ehow re Modical Examinar must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a.	Decedent's Usu (Give kind of wo	rk done du	ion uring most of	working		16b. Kind	d of Business/l	ndustry
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and	d be f antal h	Be c	William	G.	Н	ogg		Mary				Grie	r
Maryland	should be filed nd Mental Hygi marked other umatic event, I	၉	19a. Informant's Name/Relationship (7			Mailing Address	(Street ar	nd Number or	Rural Roi	ite Number	, City or	Town, State, Z	ip Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 ie marked other then "natural", or Iteme 23a or 28a-1 ehow eny injury or other traumatic event, the Madical Examinar must be notified at once.		Frederick J. Weid	ner (Grand	son) 2	03 McKin	mev	Town R	oad N	lozth	East	. Mary	land 21901
altimore,	ss 1 a of Hea item		20a. Method of Disposition	•	20b. Place of	Disposition (Nai	ne of	1	Date pril			ation - City or 1	
Ē	Pages nent of ant: If it ury or o		1 Donation 5 ☐ Other (Specify		Holv R	edeemer	Cemt	1	.pr.r.r 2	2006 E	Balti	more.	Maryland
alt	permit. Page Department of Important: If eny injury or ance.		21. Signature of Funeral Service Licen	500 / ·	- 0	W. Dal	d Address	ki/Cho	jnack	i Fur	eral	Homes	P.A.
8	20E 2		Jugark 1	· Non	acki'	1005 I	unda	lk Ave	. Bal	timor	e, M	iarylan	
			23a. Part1. Enter the disease, or compshock, or heart failure. List only	plications that caused one cause on each lin	the death. Do r e.	ot enter the mod	le of dying	, such as care	diac or res	piratory arr	est,		Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	eme	Kia							
	/Medical Examiner		[]	Due to (or as	a consequence of	of):	70	1					
	# 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	equence of	reux	100						
1	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c		Str 200	De	Die.					
Ŋ.	exec en an rial-tr		resulting in death) Last		a consequence of	of):	1						
8760,	death certificate be executed e attending physicien and by for use as the burial-transit	Physician/Medical		d				<u> </u>					
9	artifica ing pt	Med	IF FEMALE:		V							1	
Вох	eath certific attending pl	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 🗌 Fetal death						23	3d. Date of deli- Month	very Day Year
P.O.	the de	ysic	1 ☐ Yes 2 🔯 No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time or death	5 ☐ Other (sp	өспу)						
	law requires that the de es been signed by the a 2 should be detached f	H.	Part II. Other significant conditions of	ontributing to death bu	ut not resulting in	the underlying o	ause giver	n in Part I.		23e. Did tol	pacco us	e contribute to	the cause of death?
Sp.	w requires that been signed to should be det	d by							_	1 🗆 Ye	es 2 🕽	No 3□Pro	bably 4 □Unknown
of Vital Records,	s beer	Completed								24a. Was a	n	24b. Were aut	opsy findings available ompletion of cause of
æ	The lav	E O							_	autops perfori : Yes ∷	med? 2. X No	death?	2 □ No
ital	lan: rtifica	BeC	25. Was case referred to medical					26. Place of					
) 	hysic lis ce	70 E	examiner? 1 🗆 Yes 2 🔀 No	Hospital: 1 ☐ Inpatie	nt 2 ER/Ou	patient 3 DC	Other	. 4 🗆 Nursin	g Home	5 Reside	ence 6	□Other (Spec	rfy)
n O	Attending Physician: ir death. ector: After this certifics by the funeral director, i	:uo	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day		liury	8c. Injury Work	?	28d.	Describe ho	ow injury	occurred	
Sio	death death ctor: / the fi	cat	2 Accident investigation 3 Suicide 6 Could not be		ini At home fo	M Street feator		es 2 No	28f I	ocation /Si	reet and	Number or Bu	ral Route Number.
Division	after Direction by	Certification:	4 ☐ Homicide determined	building, etc	. (Specify)	in, street, ractor	y, office			City or Town			
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edicai C		ysicien: To the best of niner: On the basis of and manner sta	examination and								
	To the within 2 To the complet	Me	29b. Signature and title of certifier		17 3	29	c. License	number		2		signed (Month	
)) lind	aure	Len)		DO	0261	83			4-20	.06
	12		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type, Print)		11		-	20 1	210	. /
	<u> </u>		MAdhu SAchder.	M.D. 3	12 E. (Type, Print)	ve	VorT	h ta	51, 1	VIO	219	01
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature								
18	negisti	21	APR 2 1 2	006	is to	ALDERAS.							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Month 2113 PM Emmanuel Arnold /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KEMAKULA REGIONAL MEDIONE CONTEX 504151341 HICOMICO If Under 1 Year If Under 24 Ars. 8. Date of Birth (Month, Day, Year) 30 3/30/2006 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** M 2 ☐ F n/a Director 3/30/2006 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "natural", or Iteme 23s or 28s-f ehow the Modical Examiner must be nutified at 1X Yes 2 □ No Director Delaware Sussex Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 113 W. State St. 19975 **USA** within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Š PuertoRico 3 ☐ Widowed 4 ☐ Divorced Hispanic Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be Depertment of Health end Mental Important: If Item 27 Ie marked o Russell O. Arnold II Zerilys Laureano-Davila 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Russell O. Arnold II/father 113 W. State St., Delmar, DE 19975 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Wicomico Memorial Park 1 Deurial 2 Cremation 3 Removal from State 4/5/06 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 24 North and Address of Facility Home Professional Association David H. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Onset and Death PREMATURITY AT 22 WEETS Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical NEWBIRN Examiner ACENATED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien end the burial-transit Due to (or as a consequence of): Physician/Medical ed by the ettending of detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) o ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ page 2 should be 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificete Vital 1 Yes 21XNo 1 Yes 2 No After this certification funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ð 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification; 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours efter death.
To the Funeral Director: After Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature, and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salisbury MD. 21801 100 E. Carroll St. Inez Reeves, MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

sicia edica	_	1 - State RegistreAmend Ttem: 1. Decedent's Name (First, Middle, Las Michal	77		Abb					Date of Deal Month	Day	Year 2006	10.1	e of Death
mine		4a. Facility Name (If not institution, give	street and number)				Town, or	Location of			4c. C	ounty of Dea	ith	
			KINS HO	0501	FAL	BA.	7/4,	MORE	E CI	+4		altimo		
ral or		5. Social Security Number 6. S. 222-90-9975	ex 7. Ag □M 2∏xF	ge (In yrs. 7	last birthday) Yrs.	Months	Days	II Under 2 Hours	Min. (Date of Birth Month, Day, -24-19	Year)	_ C	thplace (Sta ountry) Laware	
		Usual Residence of Decedent 10a. State 10b. County		100 Ci	ty, Town or La	action								le City Limi
	5		0		alisbur									eocky∟imi Yes 2∏N
	Director	Md. Wicomic 10e. Street and Number		56	1113041		o Code			1	0g. Citiza	en ol What C	ountry?	
	o e	223 Wall Street				2	1804				TT .	S.A.		
	Funerai	11. Marital Status	12. Was Decedent Armed Forces?		.S. 13.	Vas Dece I Yes, spe	dent of Hi	ispanic Orig	in? (Specify Puerto Rica	Yes or No-		4. Race - Am Black, Whi		n,
	اھ	1 Mever Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🔼 If Yes, Give Year or Dates:			I □ Yes	77	Specify:		,,	5	Specify:Wh:		
	ted	15. Decedent's Ed			16a. Deced	lent's Usu	al Occupa	ation during most	of working		16b. Kin	d of Business	/Industry	
	Completed	(Specify only highest gra	College (1-4or:	5+)	life. I	00 NOT 1	ise retired))	or working		n/	10		
		17. Father's Name (First, Middle, Last)				n/a		18 Mother	's Name (Fil	et Middle				
	To Be	Jodi Abbott						_	net	31, 14110010, 1	naidon 2	omanio,		
		19a. Informant's Name/Relationship (Type, Print)			-						Town, State,		
		Jodi Abbott (Fath	er)		_			et Sal	A table I demonstrate			nd 2180		
		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □	Removal from State	(Place of Dispo	natory or o	other plac		Date			ation - City or		
	1	4 Donation 5 Other (Specify		Uad	i Fello				- 06-2			e1, De		
		21. Signature of Funeral Service Licen	of - Ha	MIM	an 70							ishar 956	oon F.	н.
ĺ		23a. Part1. Enter the disease, or compshock, or heart lailure. List only	olications that cause	d the deat	1								Approxi	mate Between
		Immediate Cause (Final disease or condition		_	ain .	Doct	-h						Onset a	DAI
		resulting in death)	Due to (or as	a consec	uence ol):								7	2
	-	Sequentially list conditions,	b. Due to for as		scardit	15							21	DAYS
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		Tot	luens	. 4	12						71	DAYS
		resulting in death) Last	Due to (or as	a consec	uence of):									
	dicai		d							·	-			
1	/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregna	ancy						23	ld. Date of de	livery	
	ciar	in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 4 ☐ Pregnant a]Ectopic p] Other (s _i					1	Month	Day	Year
	Physician/M	9 Unknown	9□ Unknown										11110	
1	<u>۾</u>	Part II. Other significant conditions of	ontributing to death b	out not res	ulting in the u	nderlying	cause give	en in Part I.	1			e contribute t	o the cause robably 4	
l	eted								-	:	es 21/2			
	Completed							-	-	24a. Was a autops perforr	y	death?	completion	of cause
	ပ္ပ	25. Was case referred to medical						26 Place	of Death (Cf		No No	1 🗌 Ye.	s 2 No	
	ToB	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2	ER/Outpatien	t 3 D	OA Othe	0.61				Other (Spe	ecify)	
		27. Manner of Death 1 ØNatural 5 ☐ Pending	28a. Date of Inju (Month, Da		28b. Time of	:	28c. Injury Work			Describe ho				
	catic	2 Accident investigation	1			М		Yes 2 □ N						
	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In building, e	jury - At h tc. <i>(Specii</i>	ome, larm, str	eet, lactor	y, office			Location (St City or Town		Number or F	ural Route I	Vumber,
- 1		29a. Certifier 1 ✓ Certifying Ph	ysician: To the best	of my kno	owledge, death	occurred	l at the tim	ne, date and	place, and	due to the ca	ause(s) a	nd manner a	s stated.	
	Medical	(Check only 2 Medical Examone)	niner: On the basis of and manner st	of examina ated.	ation and/or in	estigation	n, in my of	pinion, death	h occurred a	the time, d	ate and p	lace, and du	e to the cau	se(s)
П	Σ	29b. Signature and title of certifier	200 1	,	MO		c. License		\ <u>^</u>			signed (Mon		
			YYLO		10.0		KF2	;- OO		,	4pci	12,	200	6
	3	30. Name and address of person who) a		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 06 1813 **Physician** EARL N. ANDERS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HICOMICO FENINGULA REGIONAL 5. Social Security Number 6. Se Medica SAUSBUR Age (In yrs. last birthday, If Under 1 Year | If Under 4 Hrs. 8. Date of Birth (Month, Day, Year) 02-27-1925 9. Birthplace (State or Foreign Funeral 1 M 2□F LANDSDALE, PA. 81 Director 208-18-7229 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r then "natural", or iteme 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director MD WICOMICO DELMAR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? IISA 21875 30534 DANWOOD DRIVE by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married Married Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed 16b Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) TRUCKING TRUCK DRIVER 12 other permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: if Item 27 is marked other any injury or other trainment. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be EDNA NYCE ARTHUR F. ANDERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30534 DANWOOD DRIVE, DELMAR, MARYLAND 21875 ALLAN ANDERS - SON Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition t ☐ Burial 2√ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CREMATORY OF DELMARVA 04-06-2006 DELMAR, DELAWARE 22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. 21. Signature of Furieral Service Licenses 705 EAST MAIN STREET, SALISBURY, MARYLAND 21804 23a. Part 1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OKONARY **Physician** ARTERY DISENSS YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit and Due to (or as a consequence of) Box 68760. the ettending physician Physician/Medical use es the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de: 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? deteched for Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 2 MC STEWOSIS 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed TRIAL FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No Division of Vital the Hospitel or Attending Physician: nin 24 hours efter death. the Funarel Director: After this cartified 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 R/Outpatient ဥ 3□ DOA 28b. Time of 28c. Injury at Work? 27. Manney of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident npletely filled in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funare! 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 000 62916 05 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GUTIERREZ 1415 SOUTHAINSION SWITE & SALISAWAY MA SVETZANDA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

APR 0 6 2006

State of Maryland / Department of Health and Mental Hygiene 12566 For Stata Ragistrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 4:45 AM 4,2006 Beulah C. Applegate /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SALISBURY, MD. 21804 SALISBURY REHAB & NURSING CENTER WICOMICO 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 ☐ M 2 🕱 F 84 12, 1922 Director 144-12-1815 Jan. Delaware Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f ehow event, the Medical Examiner must be notified at 1 X Yes 2 No Director Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö or items 23a 401 D Deborah Drive 21804 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc filed within 72 hours after Hygiene. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify þ Specify: 3XXWidowed 4 □ Divorced White naturel Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene.
Importent: If Item 27 is marked other then "na any injury or other traumatic event." Elementary/Secondary (0-12) College (1-4or 5+) 8 Seamstress Garment Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Massey Helen Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Trolian (Daughter) 401 D Deborah Drive Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Odd Fellows Cemetery April 7, 2006 Laurel, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Short Funeral Home 13 East Grove Street Delmar, DE 23a. Part1. Enter the disease, or comp shock, or heart failure. List only hs that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** 2 wo /Medical resulting in death) as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (br as a consequence of Examine The law requires that the death certificate be executed use as the burial-transit and as a consequence of) been signed by the attending physicien should be detached for use as the burial Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 Ectopic pregnancy Month Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? hes autopsy performed? certificete 2 No 1 Yes 2 4 No 1 Tyes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 2 ER/Outpatient Pis 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Matural 5 Pending 1 Tes 2 No death. investigation 2 Accident Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral L To the Hospitel 12 Certifying Typician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie in 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM ROBINS, M.D. 200 CIVIC AVE., SALISBURY, MD. 21804 31. Date filed (Month, Day, Year) APR 0 7 2006 State Registrar

DHMH 17 Rev 1/2001

Applegat

				. For		aryland / De	partment of	f Health and N	•	_	12565
				State Registrar			ertificate c	or Death		Reg. No.	
-		Physici /Medic		Decedent's Name (First, Middle, Las Henry Robert		Sr.			2. Date of Dea Month April 9	, 2006 Ye	1:20 P M
		Examir		4a. Facility Name (If not institution, give				n, or Location of Death		4c. County of E	
		e in the second		Upper Chesapeake				el Air	O Date of Birth	Harfo	<u> </u>
		Funeral		5. Social Security Number 6. S 217–01–5654	ex 7. Ag EXM 2 ☐ F	ge (In yrs. last birthd 86 Yrs	Months Da		3. Date of Birth June 10	Year)919 M	Birthplace (State or Foreign Country) Lary Land
		Director		Usuel Residence of Decedent						, , , , , ,	
		yland		10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
		a-f-el	ctor	MD Harfor	rd	Havre d	le Grace				1 ☐ Yes ¾ ∰No
		72 hours after death with the Maryland "natural", or items 23e or 28e-f show colical Exertirer must be notilled at	Director	10e. Street and Number			10f. Zip Cod	le		10g. Citizen of What	t Country?
		23a	<u>a</u>	108-8 Bayland Di			210			U.S.A.	
		tems	Funeral	11. Marital Status	 Was Decedent Armed Forces? 	Ever in U.S.	 Was Decedent of If Yes, specify C 	of Hispanic Origin? (Sp Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - A Black, V	American Indian, Vhite, etc.
2	36	ori	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 XYes 2 If Yes, Give Year or Dates:	No Total T	1 ☐ Yes 2 🕱	No Specify:		Specify: W	hite .
30 fm	21215-0036	72 hours after natural', or fu	ba pa	15. Decedent's Ed			ecedent's Usual Oc	cupation		16b. Kind of Busine	ess/Industry
0	5	in 72 in 72	Completed	(Specify only highest gra	de completed)	(C	live kind of work do fe. DO NOT use re	one during most of work	king	TOD. THING OF EGSINE	oo amada y
4	212	d within jiene. r than "	E O	Elementary/Secondary (0-12)	College (1-4or		lder			Manufactu	ring
. 1	þ	e filed I Hyg othe	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle,	Maiden Sumame)	
-	<u>a</u>	uld be Aenta rked ric s	ToB	Andrew Bumba				Lydia	Mae Atc	hinson	
	altimore, Maryland	perniit. Pages 1 and 2 should be filed within Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "any righty or other traumatic svent, Ins Mag. ODG.		19a. Informant's Name/Relationship (Dianne Morris (Da	*		lailing Address (Str.) 1 Devons	eet and Number or Rui hire Ct.	ral Route Numbe Aberdee		te, Zip Code) 001
90/6	ē,	Hee Hee		20a. Method of Disposition		comptany	isposition (Name of crematory or other	f	Date	20c. Location - City	or Town, State
=	- ê	Pages ent of nt: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification Specification Specifi		Harford	Mem. Gdi	ns. 4/12	/06	Aberdeen,	Maryland
_	Ħ	parim parim porta		21. Signature of Funeral Service Licen	S00	,	22. Name and Ad	dress of Facility g-Cargo Fu	noral Ho	ma D A	
7	m	Depariment of the period of th		Kirsten Ho	right m	Slesby	Aberde	en, Maryla	nd 2100	1-3399	
		general de la companya de la company		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause	the death. Do not ine.					Approximate Interval Between
		Physician		Immediate Cause (Final disease or condition			Scho mi	. line.	ation		US hours
1		/Medical		resulting in death)	Due to (or as	a consequence of):	30,000	a linfa	40000		(5)(50)
_	-	Examiner		Sequentially list conditions,	b. Ather	osclerot	ic Vos	culos di	sease		Years
30	1-1.	pe tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					
दू	L.	and I-tran	хап	that initiated events resulting in death) Last	c Due to (or as	a consequence of):					
800389417	760,	e be executed rsicien and e burial-transit	alE								
*	687	certificate iding phys		•	d						
7	Вох (res that the death certificate igned by the attending phy be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant	23c. tf yes, outcome		_			23d. Date of	delivery
3	B	death a atte	Cia	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant a	2 Fetal death time of death	3 ☐ Ectopic pregna 5 ☐ Other (specify			Month	Day Year
70	0	that the ed by the detacher	hys	9 Unknown	9□ Unknown						
0	3, 11	gned gned	by P	Part II. Other significant conditions of	_	_		-	23e. Did to	bacco use contribut	e to the cause of death?
~	rds	w require been sig should b		Hypertension	, Chro	onic re	nal fo	iluce	1 🗆 Y	′es 2 ☐ No 3 ☐	Probably 4 Unknown
>	ecc	E 25	ple	Prostate Con	cer				24a. Was a	sv prior	autopsy findings available to completion of cause of
2	E.	sician: The lav certificete has rector, page 2	Completed	•					perfor	rmed? death	h? Yes 2□ No
구	/ita	Physician: this certific al director,	Be (25. Was case referred to medical examiner?		- 0100 W		26. Place of Dea	th Check only or	ne)	
-	<u></u>	hysi this c	ို	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpati		THEIR SELDON			lence 6 Other (S	Specify)
3		ing Phys I. After this Iuneral di	inol ::	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da	ury 28b. Tim uy Year) Inju		njury at Work? 1 ☐ Yes 2 ☐ No	280. Describe n	low injury occurred	
9	isic	Attending r death. actor: After	cat	2 Accident investigation 3 Suicide 6 Could not be		jury - At home, farm			28f. Location (S	Street and Number o	r Rural Route Number,
3	Division	after after Direct	Certification;	4 Homicide determined	building, e	ic. (Specify)	, street, racioty, on		City or Tow		7131371331371337,
Bumbo		To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificete his completely filled in by the Luneral director, page	edical C			of examination and/o		a time data and date ny opinion, death occur			
		To the within 2 To the comple	Med	29b. Signature and title of certifier	and mainter St		29c. Lic	ense number	2	29d. Date signed (M	onth, Day, Year)
		⊬ s ⊢ ŏ) Glfm	10		DO	059320		April	11 750/-
		یک ،		30. Name and address of person who	completed cause of	death (Item 23a) (Ty	pe, Print)_	osque D		, 1	, 2006
		1.1		Elie Fratti.	Tr. Man	520 Upo	er Chesc	zpeaka 1.	c. Bel.	Asc. MC	21014
		Sta		31. Date filed (Month, Day, Year)	32 Registr	rar's Signature	SOALL!				
	100	Registi	rar	APR 2 1 20	lub / //	50 00					

DHMH 17 Rev 1/2001

			1 - Stata Amend #5 per	State of Ma /fh 04-10	ryland / Der -2006 CNM	partment of Fertificate of	lealth and M <i>Death</i>	lental Hyg	iene 2006	12566
	Discontinui		1. Decedent's Name (First, Middle, Last)				Date of Deat Month	h Day Year	3. Time of Death
	Physici /Medic		Betty Louise	Burkha	rdt			April 5		8:31 P. M
	Examin	er	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death		4c. County of Death	1
			Shady Grove Adven			Rockvi		R Data of Righ	Montgome	
П	Funeral Director		5. Social Security Number 3 6. Se	x □M 2√F 7. Age	(In yrs. last birthda Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, April 2	Year) Col	place (State or Foreign intry) braska
			Usual Residence of Decedent	n o				IIPIII 2	7, 1525 11	
	ylanc		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	e Mar	cto	Maryland Montgon	ery	Damas	cus				1 ☐ Yes 2 🙀 No
	ith th	Director	10e. Street and Number			10f. Zip Code		10	Og. Citizen of What Cou	•
	ath w	rai	24600 Marlboro		- : 110		0872	- 4. V N-	14. Race - Amer	3.A.
36	permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Iteme 23a or 28e-f show any injury or other traumatic event, the Medical Examination in India alone.	by Funeral	11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Divorced	12. Was Decedent & Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:		I. Was Decedent of H If Yes, specify Cub	an, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	Black, White	, etc.
ğ	2 hou	ted	15. Decedent's Ed			edent's Usual Occup		-	16b. Kind of Business/li	ndustry
21215-0036	thin 7	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5	life	e kind of work done . DO NOT use retire	d) most of work	ing		
2	ygien yer th	S		2	Н	omemaker			Own Home	
	d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, N	Maiden Sumame)	
Z S	d Men marke	2		itt_	105 11-	ilian Addana (Canada	Edith	Frosto		- Cada)
Maryland	d2 st th and 7 ts n traun		19a. Informant's Name/Relationship (T) Winston Burkhardt		4	_			. City or Town, State, Zi s, Maryland	
_	1 en Heel tem 2		20a. Method of Disposition		20b. Place of Dis	position (Name of	1		20c. Location - City or T	
altimore,	eges ant of nt: If II		1 ☐ Burial 2 ☑ Cremation 3 ☐ I		-	ematory or other pla litan Crem	· .	14/07/06	Alexandri	a. Virginia
≣.	mit. F Sertme Fortar		21. Signature of Funeral Service Ligens		·	22. Name and Addre	ss of Facility	74707700	Funeral Hom	a. VIIIIIII
m			tokent d.	Willia	mr	26401 Ridg	i-williams ge Road,	Damascus	Funeral Hom 5, Maryland	e 20872
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused	the death. Do not e					Approximate Interval Between
ı	Physician		Immediate Cause (Final disease or condition	Rug	Lind	Aorto	Ance	ryson		Min to c
П	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):		2 0			7
Н	LXdiffiller	<u>.</u>	Sequentially list conditions,	b. Chro	a consequence of):	65 fruc	five Pu	lunere	7 Disees	70015
	bed nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events	Due to (01 as 1	a consequence or).			0		
	execunand and al-tra	xar	that initiated events resulting in death) Last	C. Due to (or as	a consequence of):					
8760,	icate be executed physicien and s the burial-transit	dical	(d						
ဖ	tifical ng phy as th	0	IE EE WAS						1	7/
O. Box	The law requires thet the death certifi sie hes been signed by the ettending l page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ HO 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of deliv Month	very Day Year
ds, P	signed b	5	Part II. Other significant conditions co	entributing to death bi	ut not resulting in the	underlying cause gr	ven in Part I.		es 2 □ No 3 ☐ Pro	the cause of death?
Vital Records, P.O.	he law requir e hes been si age 2 should l	Completed						24a. Was an autops perform	y prior to c ned? death?	opsy findings available ompletion of cause of
ita		a l	25. Was case referred to medical		os		26. Place of Deat	Will the Control of t		20.10
	Physiclen; r this certificated director,	To B	examiner? 1 Yes 2 No	Hospital: 1 🔲 Inpatie	nt 2 RVOutpat	ent 3 DOA Ott	ner: 4 🗆 Nursing Ho	me 5□Reside	nce 6 □Other (Spec	ify)
0	ding Pt h. After th funeral		27. Manner of Death 1 □ Matural 5 □ Pending	28a. Date of Injui (Month, Day	y 28b. Time		ry at rk?	28d. Describe ho	w injury occurred	
Sio	Attending or death. ector: After by the fune	catl	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □No	201 1 (2)		
Division of	l or Attendation after death Director:	Certification;	4 ☐ Homicide determined	building, etc	iry - At home, farm, c. (Specily)	street, factory, office		City or Town	reet and Number or Rui n, State)	rai Houle Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Phy	vsician: To the best	of my knowledge, de	ath occurred at the ti	me, date and place,	and due to the ca	ause(s) and manner as	stated.
	ne Ho 24 h ne Fui	edical	(Check only 2 Medical Examone)	inar: On the basis of and manner sta	examination and/or	investigation, in my	opinion, death occur	red at the time, da	ate and place, and due	to the cause(s)
	To the Hospitel within 24 hours a To the Funerel completely filled	Me	29b. Signature and title of certifier	1/		29c. Licens	se number	25	9d. Date signed (Month	, Day, Year)
	0		I Chul 1	Uh-	- mo	Di	14340	7	April C	15,2006
,	5		30. Name and address of person who o	completed cause of d			1 Contac			20050
			31. Date filed (Month, Day Year)	led ne	1147		ar center	nrive, 1	Rockville,	rial y Land
	Sta Registi		APR 0 7	2006	ar's Signature	Sperke				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State	State of Maryland / Depa	artment of Health and N rtificate of Death	- (_ 0 0 0	12567
			Registrar 1. Decedent's Name (First, Middle, Last)		Timodic of Bouin	Reg. 2. Date of Death	No.	3. Time of Death
н	Physici		Donald T P	loom		Month	Day Year	100 PM
	/Medio Examir		4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Death	Ivam	4c. County of Death	
н	LXdIIII	ici	11 1 1 1	eater Washington	Rockville Man	Mand	Manh	rem
	Funeral		5 Social Security Number / 6. Sex	7. Age (In vrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth		lace (State or Foreign
	Director		131-22-5776 4	M 20 F 75 Yrs.	Months Days Hours Min.	Month, Day, Ye 3/21/3	New	fork
	p.		Usual Residence of Decedent					
	anylar show	_	10a. State 10b. County	10c. City, Town or Lo			1	0d. Inside City Limits 1 X Yes 2 □ No
	Ba-f	Director	MD Montgomer	y Silver	Spring			
	with ti	급	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Cour	itry?
	s 236	Funeral	3200 N. Leisure Wo		20906		S.A.	
	lten Len	n.	11. Marital Status 1 □ Never Married 2 ☒ Married		Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
39	irs af	by F	3 Widowed 4 Divorced	If Yes, Give	1 ☐ Yes 2X No Specify:		Specify: Whi	te
Maryland 21215-0036	ba filed within 72 hours after death with the Maryland tal hygiene and the state of		15. Decedent's Educ	ation 16a Dece	dent's Usual Occupation	166	. Kind of Business/Inc	lustry
75	within 72 ene. than 'n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	Completed) (Give life.	kind of work done during most of work DO NDT use retired)	ing		
212	d with	E O	Clotheritary/36Cordary (0-12)	2 E.D.P.	Auditor	I1	nsurance C	ompany
פ	ba filed ital Hygi id othar event,	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Name	e (First, Middle, Maid	den Sumame)	
<u>a</u>	buld ba Mantal arkad o atic eve	To E	Julius Bloom		Ida Rosn	er		
ar	as 1 and 2 should to Health and Mant item 27 is markac rother traumatic		19a. Informant's Name/Relationship (Typ	ne, Print) 19b. Maili	ng Address (Street and Number or Rura	al Route Number, Ci	ty or Town, State, Zip	Code) 20906
	and 2 salth n 27 I		Lynne J. Bloom/Wif		North Leisure Worl	.d Blvd#60	4 Silver S	Spring, MD
ore	of He		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □R	20b. Place of Dispo	osition (Name of matory or other place)	Date 20c	. Location - City or To	wn, State
Baltimore,	mit. Pages partment of h cortant: If ite		'4 □Donation 5 □ Other (Specify)	Judean Me	m. Garden 4-2-0	06 Olı	ney, MD	
at	permit. Pag Department Important: I any Injury once.		21. Signatur of Funeral Service License	e 22	2. Name and Address of Facility ${ m EdWa}$	ard Sagel	Funeral D	irection
m	9 Q E 2 9		Migori & B	1	091 Rockville Pike	e Rockvill	Le, MD 208.	52
П			23a. Part1. Enter the disease, or complication shock, or heart failure. List only on	ations that caused the death. Do not ent e cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
Z	Pnysician		Immediate Cause (Final disease or condition	1xmars art	ery disease			Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence of):	- water			Japans
	Examiner	_	Sequentially list conditions, b					
_	pe tis	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):				
	and I-tran	Exam	that initiated events cresulting in death) Last	Due to (or as a consequence of):				
8760,	cate be axacuted physician and the burial-transit	cal E						
387	icate phys s the	edlc	0					
×	eath cartific attending p I for usa as	¥.	IF FEMALE: 23b. Was decedent pregnant	Bc. If yes, outcome of pregnancy			23d. Date of delive	rv
Box	death cartifi e attending id for usa as	Physician/M	in the past 12 months?		Ectopic pregnancy Other (specify)			Day Year
o.	y th	ysi	9 Unknown	9□ Unknown				
<u>α</u>	de de	by Pt	Part II. Other significant conditions con	tributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobaco	o use contribute to th	e cause of death?
rds	quires n sign ald be		chabetes me	litus		1 🗌 Yes	2 ☑No 3 ☐ Proba	abiy 4 DUnknown
Vital Records,	w requir s baen si should	Completed	husertencian			24a. Was an	24b. Were autop	sy findings available
æ	Thalaw atahasb page 2 sh	Ë	toot	Lifetia		autopsy performed	prior to con death?	rpletion of cause of
ta	(0	Ö	25. Was case referred to medical	infection	26. Place of Death	1 Yes 2 🗗	No 1 ☐ Yes	2 No
<u>=</u>	Physician: this certific al director,	0 0	examiner?	ospital:	Other		6 ☐Other (Specify)
ō		n: T	27. Manner of Death	28a. Date of Injury 28b. Time of		28d. Describe how in		
<u>0</u>	Attending r death. ector: After by the fune	atlo	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury	M 1 ☐ Yes 2 ☐ No			
Division	l or Atten after deat Director: in by the	ij	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	and Number or Rural	Route Number,
ā	s after al Dire	Certification;	4 _ 716millions	building, etc. (Opeany)		ony or rown, or	alo)	
	To the Hospital or Attent within 24 hours after death To tha Funeral Director: completely filled in by the	ledical	29a. Certifier 1 Certifying Phys	icien: To the best of my knowledge, death	h occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the cause	e(s) and manner as sta	ated.
	To the Ho within 24 I To the Fu	Medi	one)	and manner stated.				
	To To	Σ	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, D	Ay, rear)
	5		my 1.7h	m	11071767	IV	mun31,2	900
			30. Name and address of person who co	npleted cause of death (Item 23a) (Type,	Print)	DR. KRIS	ELISABETH	KUHN
		to.	31. Date filed (Month, Day, Year)	32. Registrar's Signature	vice veryaner			
	Sta	ite	APP 0 6 2006	E. A. H. Back	EL .			

			1 - For State Registrar	State of Marylar		artment of F tificate of			enell6 g. No.	12566
I	Physici		Decedent's Name (First, Middle, Last) Harry	Bernard		Ворр		2. Date of Death Month April 8	Day Yeer	0.4
	/Medic Examin		4a. Facility Name (If not institution, give st				or Location of Death		4c. County of Dea	2250 P M
	LXUIIII		Memorial Hosn	oital		Cum	berland		Alle	ganv
١.	Funeral		Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	o Ri	rthptace (State or Foreign country)
	Director		199-26-8012	M 2□F 69	Yrs.	Months Days	nouis Min.	04/21/1		nsylvania
	p ,		Usual Residence of Decedent	100 0						
	aryla shov	_	10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	8e-f	Director	MD Allega	any	Cu	mberland				1X Yes 2 □ No
	vith th	Öİ	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	country?
	72 hours afler death with the Maryland naturel', or Items 23a or 28e-f show Jigal Extroller mat be notified at	Funeral	220 Somerville A			215			USA	
	er de Items	une		Was Decedent Ever in U Armed Forces?	.S. 13. \	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh	
20	' or	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		I∐Yes 2∭ No	Specify:		Specify:	171
-000	turel		15. Decedent's Educ		16a Decer	ient's Usual Occup	nation	1.	6b. Kind of Business	White
Ċ	in 72 in in a	Completed	(Specify only highest grade	completed)	(Give	kind of work done DO NOT use retired	during most of word)	king	ob. Kina of Business	siliqustry
7 7	with iene. ther	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		borer	-/		Constru	ction
2	Hyg Hyg other ent,	a	17. Father's Name (First, Middle, Last)		La	DOTEL	18. Mother's Nan	ne (First, Middle, M.		CCIOII
0	ld be ental ked c	To B	Ralph Clas	re Bo	рр		Roselle	е	Deem	er
	shound Mind Mind Mind Mind Mind Mind Mind Mi	-	19a. Informant's Name/Relationship (Typ			g Address (Street	and Number or Ru	ral Route Number,	City or Town, State,	
Ĕ	od 2 lith a 27 is		Charlotte Huffman	/ friend	116	Wempe Dr	ive. Cuml	perland,	Marvland	21502
D,	f Heal		20a. Method of Disposition	20b. F		sition (Name of natory or other place	,		Oc. Location - City of	
2	age: ent ol nt: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)					0/2006	Cumberland	A MD
Dallillion	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 271s marked other then "naturel", or Items 23a or 28e-f show eny injury or other treumetic event, Item Medical Examinet and the profiled at once.		21. Signature of Funeral Service License							1 Home, P.A.
ם ם	Dep Imp		1 the 12 1	100					-	yland 21502
П	- 1-1		23a. Part1. Enter the disease, or complic	ations that caused the deat						Approximate
	Dharistan		shock, or heart failure. List only one tmmediate Cause (Final	e cause on each line.						Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Myocardial Due to (or as a conseq		ction				5 minutes
	Examiner					Ucomt Di	:			4.0
b		е	Sequentially list conditions, if any, leading to immediate	Arteriosc1 Due to (or as a conseq		пеагс D.	rsease			10 years
	uted d ansit	mi	cause. Enter Underlying Cause (Disease or injury that initiated events							
	exec n and ial-tra	Examiner	resulting in death) Last	Due to (or as a conseq	uence of):					
00/00	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burrat-transit	edical	d.							
00	uficat g phy as th									
200	death certifi attending	ician/M	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pregna		·			23d. Date of de	livery
0	death e atte	icia	in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		Ectopic pregnancy Other (specify)	/ 		Month	Day Year
5	that the death cer ed by the attendin detached for use	hys	9 □ Unknown	9□ Unknown						
, ,	tw requires that s been signed b should be deta	by P	Part II. Other significant conditions cont	ributing to death but not res	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did toba	cco use contribute t	o the cause of death?
2	quire an sig							1 ☐ Yes	2 □ No 3 □ P	robably 4 🛣 Unknown
acords,	s bee	ompleted						24a. Was an		utopsy findings available
5	The lav	шо						autopsy performe 1 ☐ Yes 2.0	death?	completion of cause of s 2 \(\subseteq \text{No} \)
Tall a		e C	25. Was case referred to medical				26. Place of Dea	th (Check only one)		2 140
	ys dis	0	examiner? 1 ∑ Yes 2 ☐ No Ho	ospital: 1 ☐ Inpatient 2 🖔	ER/Outpatien	t 3□ DOA Oth	or		ce 6 □Other (Spe	ecify)
5	g Ph	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	10,100	28d. Describe how		,,
5	ndin ath. r: Aft e fur	atlo	1 ÄNatural 5 ☐ Pending 2 ☐ Accident investigation	(World, Day 1 Sal)	injury		Yes 2 No			
IVISION	ar dei	ertification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	et and Number or R	ural Route Number,
5	s after s afte	Cert		building, etc. (Specif	<i>y</i> /			Only of TOWN,	Siare)	
	bour hour uner ly fille		29a. Certifier 1 Certifying Physi	cian: To the best of my kno	wledge, death	occurred at the tin	ne, date and place	and due to the cau	se(s) and manner a	s stated.
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	edical	(Check only 2 Medical Examination one)	er: On the basis of examina and manner stated.	uon and/or inv	estigation, in my o	pinion, death occu	rred at the time, dat	e and place, and du	e to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier			29c. License	e number	290	d. Date signed (Moni	th, Day, Year)
			I Jeans Kman			D	009231		April 10	, 2006
1	see		30. Name and address of person who con	npleted cause of death (Iten	n 23a) (Type, I	Print)				
			Donald Mang			edford Ro	oad, Cumb	erland, M	aryland	21502
	Sta		31. Date filed (Month, Day, Year) ADD 1 A 201	32. Registrar's Signa	iture	berte				

		-	1 - For State Registrar	State of M	aryland /	Departm Certific			and Mer		iene g. No. 006	12569
			Decedent's Name (First, Middle, Las	t)						Date of Death	h	3. Time of Death
	Physicia		Anna M. Bira	khead					1	Month	Day Year	I M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. 0	ity, Town, or	Location of		-	4c. County of De	ath
			Anchorage Nursir	rg and Rehal	ochtatro	<u>a</u> 5	alisbur	U			Wicomic	0
	Funeral		5. Social Security Number 6. Se		e (In yrs. last I	pirthday) If Ur	nder 1 Year	Hours 1	24 Hrs. 8. Min.	Date of Birth (Month, Day, ine 3	Year) 9. B	inthplace (State or Foreign Country)
	Director		213-12-5005	2 M 2 Z	92	Yrs.			Ju	ine 3	1913 Mai	ryland
	Mc Mc	-	Usual Residence of Decedent 10a, State 10b. County		10c. City, To	wn or Location						10d. Inside City Limits
	Mary	ŏ	Maryland Wicom	ico		Salis	hurv					1 XYes 2 □ No
	1 the	Directo	10e. Street and Number	100			Zip Code			10	Og. Citizen of What C	Country?
	h with		954 Gateway St	reet			2180)1			U.S.A	
	deat	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was D			gin? (Specify , Puerto Rica	Yes or No-	14. Race - An Black, Wh	
9	or its	F	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 ☐	No		s 2XNo	Specify:	, 1 00110 71101	un, 0.0.,	Specify:	110, 010.
ĕ	urel',	d by	3 Widowed 4 □ Divorced	Year or Dates:							В	lack
2	filed within 72 hours after death with the Marylend Hygiene. other than Insturelt, or items 23e or 28e-f ehow ent, the Madical Examinational be Hutflind at	Completed	15. Decedent's Ed (Specify only highest gra		16	Give kind o	Jsual Occup f work done o T use retired	durina most	of working	'	16b. Kind of Busines	s/Industry
2	withir ane. then	dmo	Elementary/Secondary (0-12)	College (1-4or	5+)	Dome		-/			None	
ე ე	filed Hygi other	ပိ	17. Father's Name (First, Middle, Last)			DOME	SCIC	18. Mother	r's Name (Fi	irst, Middle, N	Maiden Surname)	
an	id be ental ked c	To Be	Roy Corbin Sr.					Sal	lie N	Marv F	Purnell	
Maryland 21215-0036	shound M	-	19a. Informani's Name/Relationship (7	ype, Print)	1	9b. Mailing Add	rass (Street				City or Town, State,	Zip Code)
Σ	alth a 27 is		DeShearer Ander	(Daugnt	Ler)	124 St	one S	Shop	Cir.	Owings	Mills,	Md 21117
ore,	item item		20a. Method of Disposition		20b. Place	of Disposition tery, crematory	(Name of		Date		20c. Location - City of	
Ē	Page nent contribution		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify			en Acr			-8-06	5	Salisbu	ry,Md.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23e or 28e-1 show simply injury or other treumatic event, the Madical Examinat must be nutitied at angle.		21. Signature of Funeral Service Licen		ست	22. Nam	e and Addres	ss of Facility	y ral F	Iome		
<u> </u>	8258		Bladys B.	Stewa	2/	821	"West	r Ka.	sälis	büry,	Md.2180	1
	Physician		23a. Part1. Enter the disease, or comp shock, or head failure. List only Immediate Cause (Final disease or condition	one cause on each I	ine.	o not enter the				spiratory arre	est,	Approximate Interval Between Onset and Death
þ.	/Medical Examiner		resulting in death)	Due to (or as	a consequenc	e of):						
	Examine:	<u>.</u>	Sequentially list conditions,	b. PAILU	a consequence		RIVE					
	bed nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (0) 23	a consequent							
	ate be executed hysicien and the burial-transit	Examiner	that initiated events resulting in death) Last	C Due to (or as	a consequenc	e of):						
1760,	sicier burii	calE	(4								
89	ificate g phy as the											
Вох	thet the death certifica ed by the attending ph detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		a = 2 = 1 = 1 = 1					23d. Date of d	elivery
m	death	icia	in the past 12 menths? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 4 ☐ Pregnant a			ic pregnancy r (specify)				Month	Day Year
P.O.	by the	hys	9 🗆 Unknown	9□ Unknown								
S,	S 50	by F	Part II. Other significant conditions c	ontributing to death I	out not resulting	g in the underlyi	ng cause giv	en in Part I.				to the cause of death?
ord	w requir been si should I	ted								1 🗆 Ye	s 2 No 3 1	Probably 4 Onknown
Record	as be	Completed								24a. Was an		autopsy findings available completion of cause of
		ПO								perform 1 ☐ Yes 2	ned? death?	
Vital	ysicien: Th is certificate director, pag	Be (25. Was case referred to medical examiner?						of Death (C	heck only on	θ)	
of \	S 0 D	은	1 ☐ Yes 2 ☐ No		ent 2 ER/		DOA Oth	412 NUI			nce 6 ☐ Other (Sp	ecify)
n o	ding Phi h. After thi funeral	Certification:	27. Manper of Death ↑ ZNatural 5 ☐ Pending	28a. Date of Inj (Month, Da	ay Year) 28t	o. Time of Injury	28c. Injur Wor			. Describe ho	w injury occurred	
Division	Attending r death.	cat	2 Accident investigation 3 Suicide 6 Could not be		ius: At homo	form street to		Yes 2 1		Location (St	reet and Number or i	Pum I Pouto Number
<u>></u>	or A after Direct in by	irtif	4 Homicide determined	building, 6	tc. (Specify)	iann, street, ia	стогу, опісе		201.	City or Town		nurar noute reamber,
	To the Hospitel or Attent within 24 hours after dealt To the Funerel Director: completely filled in by the		29a. Certifier 1 Certifying Ph	vsician: To the hest	of my knowler	ige, death occu	rred at the tir	me, date and	d place, and	due to the co	ause(s) and manner	as stated
	24 h	edicai	(Check only 2 Medical Exam	niner: On the basis of and manner s	of examination	and/or investiga	ation, in my o	pinion, deat	th occurred a	at the time, da	ate and place, and d	ue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. Licens	e number		25	9d. Date signed (Mo	nth, Day, Year)
	- > - 0		> Mange	MD			江西	422			4/4/6	
1	In		30. Name and address of person who	completed cause of	death (Item 23	a) (Type, Print)	" CLAY	122			11 11	
-	in		NEMAL DOSH	I MD 10	6 MILF	ORD S	TREET	,8U	FE 504	B SP	MISBURI	1 MD 21804
	Sta	ate	31. Date filed (Month, Day, Year)	32. Segist	rar's Signature	Loan	4)					

Physi	cian	1. Decedent's Name (First, Middle, La	ist)	1,03-22 Cal	tibicate of L	Death CNM	2. Date of Death	g. No. U 0 6 03/16/2006 Pay Year	1 2 5 7 0 3. Time of Death
/Med Exan	dical	LOUISE MAY BLAIF 4a. Facility Name (If not institution, given FREDERICK MEMRO)	re street and number)		4b. City, Town, or FREDERIC	Location of Death	MARCH	4c. County of Death	
Funera Directo		,	Sex 7. Age 1	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 9,		nplace (State or Foreign untry) aryland
Maryland a-f show	ctor	10a. State 10b. County Maryland Freder		10c. City, Town or Lo					10d. Inside City Limits 1 ✓ Yes 2 ☐ No
ath with the 23a or 28	Funeral Director	10e. Street and Number 109 Tacoma Street			10f. Zip Code 2178	8	10	g. Citizen of What Cou	untry?
ING 21215-0036 be filed within 72 hours after death with the Maryland atal Hygiene. d other than "natural", or itams 23e or 28e-f show event, the Medical Exerciter noval terricities at	d by Fune	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 Tyes 2 DNo If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cubar 1 Yes 2 No	spanic Origin? (Spe n, Mexican, Puerto i Specify:	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
21215-0036 ad within 72 hours af giene. er than "naturel, or t, the Medical Exerci-	Completed	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired, y Control	luring most of workii)	ng	Sb. Kind of Business/liblack& Deck	
faryland 2 2 should be filed and Mental Hygis is marked other	To Be C	17. Father's Name (First, Middle, Last George Wilbur Bro	wn			18. Mother's Name Ethel B	(First, Middle, Ma axter	aiden Sumame)	
IOCE, Maryla ges 1 and 2 should tt of Health and Men if Item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Thomas Brown - ne 20a. Mathyd of Disposition	phew	9123 20b. Place of Dispo	Rocky Rid	ge Road,	Rocky Ri	City or Town, State, Zi dge, Maryl Dc. Location - City or T	and 21778
Baitimore, Maryland permit. Pages 1 and 2 should be file Oppartment of Health and Mental Hy importent: if item 27 is marked oth any injury or other traumatic eveni		1 Deurial 2 Cremation 3 C 4 Donation 5 Other (Special 21. Signature of Funeral Service Lice	(y)	Blue Ridge	. Name and Addres	y March s of Facility Sta	uffer Fu	Thurmont, neral Home rick, Mary	
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68 / 6U, ificate be executed g physicien and as the burial-transit	edical Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	consequence of):					
the death cert y the attendin	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tin 9 ☐ Unknown	☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
w requires that been signed by	DA	Part II. Other significant conditions of			nderlying cause give AL PISK			cco use contribute to t	
	Completed	COPD					24a. Was an autopsy performe	d? death?	opsy findings available impletion of cause of
Physician: Physician: rthis certifica	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	2 ER/Outpatien	Other	26. Place of Death		a 500 to	
r Attending Physics death.	Certification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not b	28a. Date of Injury (Month, Day Y	28b. Time of Injury	28c. Injury Work' M 1 🗆 Y	at 2 ? es 2 \(\sum No	8d. Describe how		
	E	4 Homicide determined		r - At home, farm, stre (Specify)	eet, factory, office		City or Town,		al Route Number,
		202 Cartifier 1 Cartifying Ph	valaians To the best of			4.4			
	Medical Ce	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exar 29b. Signature and title of certifier	ysician: To the best of r niner: On the basis of ex and manner stated	camination and/or inv	occurred at the time estigation, in my opi	inion, death occurre	d at the time, date	and place, and due to	o the cause(s)
To the Hospital or Atte within 24 hours after de To the Funeral Direct completely filled in by th		one)	and manner stated	kamination and/or inv d.	estigation, in my opi	number	d at the time, date	se(s) and manner as see and place, and due to Date signed (Month,	Day, Year)

State of Maryland / Department of Health and Mental Hygienen 1 - For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** APRIL 15 2006 7:00a M CHARLES CASEY, SR. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1614 Dudley Corners Rd. Queen Anne's Millington If Under 1 Year If Under 24 Hrs. 8 Date of Birth (Months, Days, Y Feb 8 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1<u>₩</u> M 2□ F 84 Director 219-34-4179 Mary land Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Queen Anne's Millington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 1614 Dudley Corners Rd. 21651 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 212 No Specify. δ Specify White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Retail Flementary/Secondary (0-12) College (1-4or 5+) Owner - Operator 6 Agricultural Equip. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Samuel Casey Rose Hartman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21651 Mildred B. Casey (wife) 1614 Dudley Corners Rd. Millington, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify). Crumpton Cemetery 4/20/06 Crumpton, MD. 21. Sandlere 1 Filhern Service Lastrisee 22. Name and Address of Facility Galena Funeral Home of Stephen L Schaech 118 West Cross St. Galena, MD. 21635 M00510 118 West Cross 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ce. Approximate Interval Between Onset and Death Immediate Cause (Final Privoician disease or inditional resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Iding physician and ise as the burial-transit be executed Due to (or as a consequence of) Box 68760. Physician/Medical as IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for us 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) detached Records, P.O. the 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 TYes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion obcause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy performed? Yes 2 No certificate 1 Yes Division of Vital 25. Was case referred edical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 27. Mann of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation after death 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 \(\text{Homicide} \) filled within 24 hours a To the Funerel C To the Hospitel 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)_ 29c. License number Signature and titl 29d. Date signed (Month, Day, Year) D3605 mo April 17, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patrick Shanahan, M.D. 120 Speer Rd. Chestertown, MD. 21620 31. Date filed (Month 2 1 2006 32 egistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydierie O. O. C.

			1 - For State Registrar	State of M	arylar				lealth a D <i>eath</i>	nd Me	ntal Hy	/giene Reg. No	, U U	6	12572
			Decedent's Name (First, Middle, La	ist)						2	Date of De	eath			3. Time of Death
	Physici /Medi		Henry William Ch	errington	TT					A	Pril	3 Da	2006	Year	3:00 9 M
F	Examir		4a. Facility Name (If not institution, given	re street and number)			4b. City	, Town, or	Location of		1			of Death	
	Funeral		Buttimore Wushingt 5. Social Security Number 6.5	Sex 7. Ag		C(. last birthday)		er 1 Year	If Under 2	4 Hrs. 8	Date of Bir (Month, Da				ONDE/ place (State or Foreign ptry)
ı.	Director		135-14-1236	1XIM 2□F 85		Yrs.			1.00.0		arch				aware
	and w		Usual Residence of Decedent 10a, State 10b, County		10c. C	ity. Town or Lo	ocation							1	Od. Inside City Limits
	death with the Maryland ima 23a or 28a-f show I must be notified at	ō	Maryland Anne Ar	undel	Ann	apolis									1 ∑Yes 2 ☐ No
	the 1	Director	10e. Street and Number				10f 7	ip Code				10a Cit	tizen of V	What Cour	
	Mith Ba or		1050TD Eaglewood	Pood			214								•
	ma 2:	era	11. Marital Status	12. Was Decedent	Ever in U	J.S. 13.			ispanic Orig	in? (Specif	v Yes or No			State	
920	be filed within 72 hours after death with the Marylan hat Hygiene. ed other than "natural", or flema 23a or 28a-f show event, the Maulcal Examiner must be notified at	by Funeral	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	Armed Forces? 1 X Yes 2 If Yes, Give Year or Dates:	,	941-	If Yes, spi 1 ☐ Yes		ispanic Orig in, Mexican, Specify:	Puèrto Ric	an, etc.)			k, White,	
Õ	72 ho	ted	15. Decedent's E	ducation		16a. Dece	dent's Usi	ual Occupa	ation			16b. K	ind of Bu	usiness/Inc	dustry
Maryland 21215-0036	e filed within 7 ti Hygiene. other than "n	Completed	(Specify only highest grant Elementary/Secondary (0-12)	College (1-4or:	5+)		olone		during most	of working		II.	S. A	ir Fo	rce
פ	be filed tal Hygid d other	Bec	17. Father's Name (First, Middle, Last)					18. Mother	's Name (F	irst, Middle				
<u>laı</u>	uld b Menta urked	To E	William Putnam						D orot h	y Fo	x Corl	kren			
an	2 should be and Mental is marked aumatic ev		19a. Informant's Name/Relationship (* * * * * * * * * * * * * * * * * * * *		19b. Mailir	ng Addres	s (Street a	and Number	or Rural R	oute Numb	er, City	or Town,	State, Zip	Code)
	s 1 and 2 of Health Item 27 i		Stephen Cherringto	on / Son		and the second second				eet N	W Was	shing	gton	D.C.	. 20016
Baltimore,	permit. Pages 1 and 2 should Department of Health and Mer Important: if Item 27 is marke any njury or other traumatic once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State		Place of Dispo cemetery, crem rt Line	-			1/5/20	906			City or To	wn, State Iary land
Balt	Deportr Imports any nj		21. Signature of Funeral Service Lice	nsee	die .	22	2. Name a	ind Addres	s of Facility	John Juces	n M. 7	Tay 1	or F	unera	al Home, Inc.
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the dea										Approximate Interval Between
H	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Hy Por	XIC			bru	-	ilu	2				Poset and Death
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	tificate be executed g physicien and as the burial-transit	Examiner	Cause (Disease or injury that initiated events	. Hyp	este	20 800	1								Sears
90,	Sien a	ũ	resulting in death) Last	Due to/(or as	a consec	quence of):									
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Box 6	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Feta	al death 3		pregnancy					23d. Dat	e of delive	ry Day Year
o	the d y the iched	ysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown	tarre or c	36atii 5 <u>C</u>	Other (s	pacity)							
<u>α</u>	The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use	þ	Part II. Other significant conditions of	contributing to death b	ut not res	sulting in the u	nderlying	cause give	n in Part I.			obacco u Yes 21		ibute to th	e cause of death?
Ö	w rec	lete									24a. Was	an	24h V	Vere autor	osy findings available
Vital Records,	n: The la ficate has n, page 2	e Completed									autor		P	rior to con leath?	npletion of cause of
	sicia centi irecto	0	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:		150/0		Othe			heck only o				
Division of	Attending Physician: r death. sctor: After this certification in the funeral director, in	tion: To	27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da		28b. Time of Injury		28c. Injury Work	at	28d	5 🗌 Resid				")
Divisi	al or Atter a after dea I Director d in by the	Certification:	3 Suicide 6 Could not b	e One Diese of Inc	ury - At h c. (Specif	ome, farm, stre fy)					Location (S City or Tox	Street an wn, State	d Numbe	er or Rurai	Route Number,
	To the Hospital or Attending Physician: The lav within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier (Check only one)	eysician: To the best niner: On the basis of and manner sta	f examina	owledge, death	occurred vestigation	at the tim	e, date and nnion, death	place, and occurred a	due to the	cause(s) date and	and mai place, a	nner as sta ind due to	ated. the cause(s)
- 6	Withir To th comp	M	29b. Signature and title of certifier				29	c. License	number			29d. Dat	e signed	(Month, L	Day, Year)
)	-		Maria Va	UNO				000	32	744		41	3/	200	6
			30, Name and address of person who	completed cause of d	eath (Iten	n 23a) (Type,									
_			Uncia GAVIRIA	MD 3		Hospil		Dri	ve	Glo	n Ru	avit	4	10	2:061
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 6 2	32. Pegistra				e			-				

Cherrington, Heary

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Bruce Lorimer Courtney Apri1 6, 12:00P 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 406 - 9th Avenue Brunswick Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 12, 1929 6. Sex 1 M 2 ☐ F Birthplace (State or Foreign Country)
 MA 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 76 Director 006-24-6364 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Count Item 27 is marked other than "natural", or Itame 23a or 28e-f abov other treumatic event, the Medical Examinar must be notified at 1X Yes 2 No Director Frederick Brunswick 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 21716 USA 406 - 9th Avenue Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: 1955-1961 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural; or Itar any injury or other treumatic event, the Medical Examinat 2008. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Electrician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frances Springer Charles LeSan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 7104 Ladyslipper Lane - Upper Marlboro, MD 20772 Paul R. Courtney - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, MD 4/8/06 Hagerstown Crematory 21. Signature of Funeral Service License 22. Name and Address of Facility John T. Williams Funeral Home Brunswick, MD 21716 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 10 a /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the attending physicien and thed for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the at id be detached for ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 robably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes page 2 s autopsy certificate 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ER/Outpatient 3 DOA Ē P this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Natural 5 Pending 1 Yes 2 No investigation 2 Accident within 24 hours after deati To the Funerel Director: filled in by the 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 \(\text{Homicide} Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one)

State Registrar

31. Date liled (Month, Day, Year) APR 0 2006 7

30. Name and address of person whe completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Kanan Hudhud, MD

Tohuran lowe Frederick up 21702 Thomas

mi

29c. License number

D41866

29d. Date signed (Month, Day, Year)

			For State Registrar	State of Maryla	nd / Depa		Health and	•		006	12574
	Physici /Medi Examir	al	Decedent's Name (First, Middle, Lass Augrey . 4a. Eacility Name (If not institution, give	CONVERS street and nymber)			or Location of Deat	2. Date of Do Month	Day	2006 County of Death	3. Time of Death
	Funeral Director		5. Social Security Number 6. Se	DM 000	fq/ . last birthday) 91 Yrs.	If Under 1 Year Months Days			rth ay, Year)	Coul	ngton, DC
	the Maryland 28a-f ehow	ector	10a. State 10b. County MD Prince (ity, Town or Lo				10g Citi	zen of What Cou	10d. Inside City Limits Yes 2 No
_Q	72 hours after death with the Maryland naturel', or iteme 23a or 28a-f show disal Evaminar must be positived at	Funeral Director	1906 Gaither Stree 11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No		20 Was Decedent of If Yes, specify Cul	748 Hispanic Origin? (S pan, Mexican, Puer	pecify Yes or No	Un	ited Sta 14. Race - Americ Black, White,	can Indian,
Maryland 21215-0036	within 72 hours a ene. then "naturel", o	Completed by	3 Widowed 4 □ Divorced 15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		16a. Dece (Give			rking		Specify: Bla	
/land 21	be filed stal Hygi ed other	To Be Con	10th 17. Father's Name (First, Middle, Last) Clarence Green		Unkno	wn	18. Mother's Nar	me (First, Middle		NOWN Sumame)	
	1 and 2 sho Health and 1em 27 ie m		19a. Informant's Name/Relationship (7 Stevie Conyers 20a. Method of Disposition	Son 20b.	100		t and Number or Ri roadway #		timo		231
Baltimore,	permit. Pages Department of I Important: If its any njury or o		1 Burial Cremation 3 4 Donation 5 Other (Specify	Ri	iverdal	e Park C Austin R		.0/06 meral H	ome	erdale,M	
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3760,	te be executed ysicien and burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. End star Due to (or as a conse c	quence of):	Zheun	dement	ર ેવ		ja J	at row
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ital Rec		e Completed	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes	psy ormed2 2 No		psy findings available impletion of cause of 2 No
Division of Vital Records,	Attending Physician: r death. ector: After this certific by the funeral director.	မ	examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other:						idence 6	5 □Other (Specif y occurred	v)
Divis	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	ai Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At houlding, etc. (Spec	ify)			City or To	wn, State)		
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	5		30. Name and address of person who of Roral AN FAR 31. Date filed (Month, Day, Year)	completed cause of death (Ite 2 A I + I F A R 32 Registrar's Sign	m 23a) (Type,	Print) 900 Ge	arzia Au	esnit =	3-41	silm g	ory MO
	Sta Registi		APR 0 6 20	106 Been 1	K A	east.					

			1 - For State Registrar	State	of Marylar	id / Depa <i>Cei</i>	artment rtificate	t of H e <i>of L</i>	lealth ar D <i>eath</i>	nd Me		giene No.	06	12575
			1. Decedent's Name (First, Middle,	Last)						2	. Date of Dea			3. Time of Death
4	Physici /Medic		Catharine Murp	hy Coli	lins					I	Month April	3, Day	2006	12:25 PM
	Examin		4a. Facility Name (If not institution,	give street and n	ımber)		4b. City,	Town, or	Location of [Death			ounty of Deat	h
			3701 Internation	nal Driv	7e, #430		Sil	ver	Spring	g		Montgomery		
	- Funeral		5. Social Security Number 6	. Sex	7. Age (In yrs.	last birthday)	If Under		If Under 24		Date of Birth) Vone)	9. Birti	hplace (State or Foreign
	Director		215-48-0303	1□M 2∰F	96	Yrs.	Months	Days	Hours	Min.	(Month, Day July 2,	190	9 Was	hington, DC
	<u>P</u>		Usuaf Residence of Decedent											
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	Ba-f	cto	Maryland Montg	omery	Si	lver S	pring							1 ☐ Yes 2 ANo
	4 within 72 hours after death with the Maryland jiene. r then "natural", or Items 23a or 28a-f ehow the Madical Examiner mant be mailfied at	Director	10e. Street and Number				10f. Zip	Code			1	10g. Citize	en of What Co	untry?
	ath w		3701 Internati	onal Dr	Lve, #43	0	209	06					USA	
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36	or I	by F	1 Never Married 2 Marne	If Yes, G		,	1 ☐ Yes 2	® No	Specify:			S	Specify: Whi	
215-003	ural'		3. Widowed 4 □ Divorced	Year or I	Dates:	1		_						
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	within 72 ene. then "na'	m d	Elementary/Secondary (0-12) 12	College	(1-4or 5+)	Owne		<i>a raurau,</i>	/			Fun	eral H	OMA
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VII	Physician: The lav this certificate has ral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:				Othe			Check only on			
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DIVISION	after Dire	erti	4 ☐ Homicide determine	build	ling, etc. (Specif)	<i>')</i>	edi, lactory,	OITICE		201	City or Town	, State)	VUITIDET OF FIGI	ar noute ryumber,
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	e Ho 24 h e Fur	edical	(Check only 2 Medical Ex	aminer: On the b	pasis of examinationer stated.	tion and/or inv	estigation.	in my op	inion, death o	occurred	at the time, da	ate and pl	lace, and due	to the cause(s)
	To the complete compl	Me	29b. Signature and title of certifier				29c.	License	number		25	9d. Date s	signed (Month,	. Day, Year)
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	2	-	30. Name and addless of person wh	o completed can	se of death (Item	23a) (Type 5	Print)	1 1	1010					
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rice.	Sta	te	31. Date filed (Month, Day, Year)		Registrar's Signa	ture 🌈	40				1100	CUTT	00 1001	, - 5-119
	Registr		APR 06:	2006	aur B	1 400	May 1							

			For State Registrar	State o	f Marylar		artment o rtificate d			1ental Hy	/giena	'IIIIh	12576		
		*	1. Decedent's Name (First, Middle, Las	st)						2. Date of D	eath		3. Time of Death		
	Physici		Clare Web	er Cav	anaugh					Month	Da		3.4		
	/Medic Examir		4a. Facility Name (If not institution, give	street and nu	m <i>ber)</i>		April 5 2006 7 4b. City, Town, or Location of Death 4c. County of Death					7:00 A ^m			
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- "	D		Usual Residence of Decedent				L			Whiri	2001	. 505	IA		
	yland Jow		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation						10d. Inside City Limits		
	Mar	to	MD Montgom	erv		1	Rockvil	16					1 ☐ Yes 2 X No		
	7.282	Director	10e. Street and Number				10f. Zip Cod				10g. Cit	tizen of What (Country?		
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	72 hours after death with the Maryland natural', or items 23a or 28a-1 show dical Exerting in the codified at	Funeral	11. Marital Status	12. Was Deci	edent Ever in U	.S. 13.			Origin? (Sp	ecify Yes or N			nerican Indian,		
(0	rite	Fur	1 Never Married 2 Married	Armed Fo 1 ☐ Yes	2 X No		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					Black, Wh			
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	othe othe	Be C	17. Father's Name (First, Middle, Last)			-				e (First, Middle	, Maiden	Sumame)			
lan	ld be enta ked lc •v	To B	Carl Augest Web	er				Ma	ry An	n Meek					
Maryland	shound Minar		19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailir	ng Address (Str	reet and Num	ber or Rura	al Route Numb	oer. City o	or Town, State	, Zip Code) 20886		
Š	od 2 lth a 27 ts		Sandra Diane Cava	gnter i naugh	in law								age, MD		
ē,	Hea Hea		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name o natory or other	f		Date		ocation - City of			
<u></u>	age ut of		1 Burial 2 X Cremation 3 D		State Med	tropoli	tan	place)	April 200	. 5		•			
Baltimore,	it. P.		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service License			Crema	Lory . Name and Ad						, Virginia		
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Вох	eath certifi attending I for use as	7	200. Has decedent program		come of pregna		Ectopic pregna					23d. Date of de	elivery		
<u>.</u>	deat e att	lcle	in the past 12 months? 1 ☐ Yes 2 🎇 No	4□Pregn	ant at time of d		Other (specify					Month	Day Year		
Ö.	that the de ed by the a detached f	Physician/Me	9 Unknown	9∐ Unkno	own										
٣.	The law requires that the death certificate has been signed by the attending tage 2 should be detached for use as	by P	Part II. Other significant conditions co	_		_		4		23e. Did	tobacco u	use contribute	to the cause of death?		
ğ	quire n sig uld b	De L	generalized a	rterios	scleros	is, ost	eoarth	ritis,		1 🗆	Yes 2	X No 3 □ F	Probably 4 Unknown		
00	w requir been si should	Completed	subluxation,	Dememti	ia					24a. Was	an	24h Were :	autopsy findings available		
Records,	The lar	m								auto		prior to death?	completion of cause of		
ल			or W.							1 Yes	2 🛛 No		s 2 No		
Vital	Physician: r this certificatal director,	Be	25. Was case referred to medical examiner?	Hospital:				O+h		Check only			Assisted		
	Phys this aldi	2	1 ☐ Yes 2 🛣 No 27. Manner of Death	1 📖 1		ER/Outpatien	. 30 000					6 XOther (Sp	ecity) Living		
Ë	ding After funer	on	1 XNatural 5 ☐ Pending	28a. Date ((Mont	h, Day Year)	28b. Time of Injury		njury at Work?		28d. Describe	now injur	y occurred	9		
Division of	Attending ir death. ector: Afte by the fune	ertification;	2 Accident investigation 3 Suicide 6 Could not be					I ☐ Yes 2[
	or Attendater deat Director:	E	4 Homicide determined	286. Place	of Injury - At he ng, etc. (Specif	ome, tarm, stri y)	eet, factory, offi	ce	1	28f. Location (City or To	Street an wn, State	d Number or F)	Rural Route Number,		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	O	T2	-											
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier 1X Certifying Phy	mer: On the ba	asis of examina	wledge, death	occurred at th	e time, date a	and place, a	and due to the	date and	and manner a	as stated.		
	To the h within 2 To the F complete	Med		and man	ner stated.										
	To with	Σ	29b. Signature and title of certifier	1/	auc	0		ense numbe	r				signed (Month, Day, Year)		
)	10		· O Come	16	our		D2	25410		and the same	Apri	pril 5, 2006			
			30. Name and address of person who c												
			Oliver J. Lawless				Philip	Drive	, Olne	ey, MD	2083	2			
	Sta		31. Date filed (Month, Day, Year) APR 0 6 20		egistrar's Signa	K L	all					-			
1000	Registr	ar	APR 06 20	IIIn FE	Bull &										

			For State Registrar	State of Mary			f Health a of Death	nd Menta	l Hygiene Reg. No	2000	12577	
	Physici	an	1. Decedent's Name (First, Middle, Las					2. Date Mor	e of Death nth Da	y Year	3. Time of Death	
	/Media		Carolyn Dia		r			4/	3/200	6	11:20p M	
No.	Examir	ier	4a. Facility Name (If not institution, give Holy Cross Hos			4b. City, Tow Silve	n, or Location of r Spri			:. County of Deat		
	Funeral Director		579-64-8555	555 1□M 2፟AF 57 Yrs. Months Di					8. Date of Birth (Month, Day, Year) 2/20/1949 8. Birthplace (State Country) ROCKY Mt			
	Maryland	tor	Usual Residence of Decedent 10a. State Md 10b. County Prince		oc. City, Town or Lo Springda						10d. Inside City Limits 1 ☐ Yes 2X No	
	or 28e	lirec	10e. Street and Number			10f. Zip Coo	le		10g. Ci	tizen of What Co	untry?	
	ath wi	rai	3800 Asquith C	ourt		2	0774		U.S	S.A.		
336	should be filed within 72 hours after death with the Maryland of Mental Hygiene, marked other than "natural; or Itams 23a or 28e-f ehow matic avent, the Madical Examiner must be notified at	by Funeral Director	11. Maritaf Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Vas Decedent Yes, specify 0 □ Yes 2⊠	of Hispanic Orig Juban, Mexican, No Specify:	in? (Specify Ye: Puerto Rican, e	s or No- etc.)	14. Race - Ame Black, White Specify: b1	e, etc.	
21215-0036	within 72 hou ene. than "natura he Med Cal E	Completed	15. Decedent's Edit (Specify only highest grade	ucation fe completed) Coflege (1-4or 5+)	16a. Deced (Give life. L	lent's Usual Ockind of work do NOT use re	cupation ne during most tired)	of working	16b. K	16b. Kind of Business/Industry		
7	filed wil Hygien Sther th	Con		2	unem	ployed				one		
Maryland	ntal H ed oth	Be	17. Father's Name (First, Middle, Last) George Carter					's Name <i>(First,</i> elrene	^{Middle, Maider} Park	•		
Ž	should be ind Mental I is marked o	၉	19a. Informant's Name/Relationship (T	vpe, Print)	19b. Mailin	a Address (Str				or Town, State, 2	Tin Code	
	1 and 2 Health a Jun 27 is ther tre		Eric Scott/ sor	1	1	Flor	da Ave				DC 20002 own, State	
Ĕ	Pages ment of I		1 ☑ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,		George							
Baltimore,	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service disease	ad o	//L		dress of Facility nedy S	Unive	ersal V. Was	Mortua: hingto	ry n,DC 20011	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the ne cause on each fine.	death. Do not ente	or the mode of	dying, such as c	ardiac or respira	atory arrest,		Approximate Interval Between Onset and Death	
)	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Respira		rest					Crise and Death	
	Examiner		- 1	Due to (or as a co		Failu	ro					
	D =	ner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	or badduerice (II).	rallu	re					
	ecuter and trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Metasta		east	cancer					
8/60,	icate be executed physician and s the burial-transit	dicai E		Liver F		enal	failur	e				
. Box	death certifi e ettending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	⊒Ectopic pregnancy] Other (specify)				23d. Date of defivery Month Day			
т Э	2 P B	/ Ph	Part II. Other significant conditions co	ntributing to death but no	ot resulting in the un	derlying cause	given in Part I.	236	. Did tobacco i	use contribute to	the cause of death?	
Kecords,	w requires that the been signed by the should be detache	ted by									obably 4 🔀 Unknown	
	The law ate has b page 2 si	Completed						-	. Was an autopsy performed? Yes 2. ☑No	death?	topsy findings available completion of cause of 2□ No	
VITAI	Physician: this certific ral director.	Be	25. Was case referred to medical examiner?	Hospital:			Othor	of Death (Check				
ō	Phy this ral d	. To	1 Yes 2 XNo 1	1 Minpatient 28a. Date of Injury	2 ☐ ER/Outpatient 28b. Time of	3LI DOA	4 🗀 19075		Residence	6 □Other (Spec	uty)	
<u></u>	Attending I ir death. ector: After by the funer	atior	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	ar) Injury		njuryat Vork? □Yes 2□No			y coodings		
DIVISION	2 2 2 2	Certification	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, stre	reet, factory, office 28f. Location			ation (Street ar. or Town, State	n (Street and Number or Rural Route Number, Town, State)		
	F T P	edicai	one) 2 Medical Exami	sician: To the best of m ner: On the basis of exa and manner stated.	amination and/or inv	occurred at the estigation, in m	time, date and y opinion, death	place, and due occurred at the	to the cause(s)	and manner as d place, and due	stated. to the cause(s)	
)	To the within 2 To the complet	X	29b. Signature and title of certifier	- Brkans	MX	29c. Lice D63	390			te signed (Month 1 / 2006	, Day, Year)	
	>		30. Name and address of person who co					_			20910_	
			Dr. Etonde Muso:	-	01		rest G	len Rd	.,Silv	er Spr	ing,Md	
	Sta Registr	te ar	31. Date filed (Month, Day, Year) APR 0 6 20	32 Registrar's	Signature Control	well .						

			4 101	rtment of Health and Mental F	Hygiene						
	Physici	an	Decedent's Name (First, Middle, Last)	2. Date of							
	/Media	cal	SAMUEL MARTIN CLOPPE 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death							
	Examin	ier	MEMORIAL HOSPITAL	CUMBERLAND	ALLEGANY						
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year II Under 24 Hrs. 8, Date of							
	Director		219-14-6365 TSM 22 F 82 Yrs. Usual Residence of Decedent	11/1	2/1923 Maryland						
	ryland how		10a. State 10b. County 10c. City, Town or Loc	ation	10d. Inside City Limits						
	8a-fs	Director	MD Allegany	Cumberland	1 ☐ Yes 2 ☐ No						
	with t	201	10e. Street and Number 15500 01d Hancock Road, NE	10f. Zip Code 21502	10g. Citizen of What Country? USA						
	death	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	/as Decedent of Hispanic Origin? (Specify Yes or Yes, specify Cuban, Mexican, Puerto Rican, etc.)	No- 14. Race - American Indian,						
36	s after , or Ite	by Fu	If Yes, Give	Yes 2\(\overline{\Omega}\) No Specify:	Black, White, etc. Specify:						
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than 'natural', or Iteme 23e or 28e-f show imatic event, the Medical Examinar must be notified at	ted b	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1947 15. Decedent's Education 16a. Decede	ent's Usual Occupation	White 16b. Kind of Business/Industry						
212	thin 7:	Completed	(Specify only highest grade completed) (Give killer. D	rind of work done during most of working O NOT use retired)	,						
2	iled wi Hygien Ther th	Con	10 W	elder 18. Mother's Name (First, Midd	Tire and Rubber						
auc	ed ta b	To Be	1027		Mae Foreman						
ary	2 should and Men is marks aumatic	-		Address (Street and Number or Rural Route Nur							
S o	s 1 and 2 should if Health and Men Item 27 is marks other traumatic			0 Old Hancock Road, NE	*						
altimore,	Pages I nent of H int: if Ite iry or ot		20a. Method of Disposition 1 Burial 2 Screenision 3 Removal from State 20b. Place of Disposicemetary, crem.	l l	20c. Location - City or Town, State						
altin	그 문원 중 .			d Crematory $04/04/2006$ Name and Address of Facility Adams Fa	Cumberland, MD amily Funeral Home, P.A.						
<u>~</u>	Depa Depa Impo			04 Decatur Street, Cuml	,						
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.		Interval Between						
	Physician /Medical			AL HEMORRHAG	E 1 day						
	Examiner		Due to (or as a consequence of): HYPERTENS	18N	Unknown						
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1011							
	and and II-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last								
8760,	cate be executed bhysicien and the burial-transit	dicai E	d								
9	The law requires that the death certificate be executed its has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Medi	IF FEMALE:								
Вох	leath certific attending pl	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Vec 3 Vec 4 Pregnant at time of death 5 1 Vec 4 Vec 4 Pregnant at time of death 5 1 Vec 4 Vec 5 Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year							
P.O.	t the d by the ached	hysi	1 UYes 2 No 9 Unknown	Juliot (Specially)	-						
S,	w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions contributing to death out not resulting in the unc		d tobacco use contribute to the cause of death?						
Ö	requir	eted		1.0	☐ Yes 2☐ No 3☐ Probably 4 X Unknown						
Division of Vital Records,	he law e has l	Completed	AdenocARYNOMA OF LUN STATUS POST SURGERY	pe	topsy prior to completion of cause of death?						
Ē	lan: T	Be Co	25. Was case relerred to medical	1 Yes	s 2⊠ No 1 □ Yes 2 □ No						
<u>></u>	Attending Physician: The Is redath. ector: After this certificate haby the funeral director, page 2	၉	examiner? 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient	3□ DOA Other: 4□ Nursing Home 5□ Re	esidence 6 Other (Specify)						
סחס	After	Certification:	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 1 ☐ Ves 2 ☐ No.								
ĬS N	or Attendater death	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street	et, lactory, office 28f. Location	(Street and Number or Rural Route Number,						
	ital or irs afte ral Dir led in				Town, State)						
	To the Hospital or Al within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death of the basis of examination and/or investance and manner stated.	occurred at the time, date and place, and due to the stigation, in my opinion, death occurred at the time	ne cause(s) and manner as stated. e, date and place, and due to the cause(s)						
,	To the Ho within 24 I To the Fu completely	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)						
4	IVA		HOSPITALIS	J D03116	04-04-2006						
	1180		30. Name and address of person who completed cause of death (Item 23a) (Type, P HASNAIN, WIRASAT, M.D., 900 SETON DRIV		. MD 21502						
	Sta		31. Date filed (Month, Day, Year) 32 Registrar's Signature		, III 21302						
	Registr	ar	APR 0 4 2006								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier (2) For Stete Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 3:55 P [™] April 3. 2006 Paul James Chicca /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** l Cutlass Dr. Berlin Worcester | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Feb. | 13, 15 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1(XM 2□ F 1925 Washington,D.C. 579-20-9708 81 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other then "naturel", or Items 23s or 28s-1 show other treumstic event, the Madical Examiner must be notified at 1 ☐ Yes 2**/**○XNo Director Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Cutlass Dr. 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No Navy If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 is marked other then "naturel", or ite 1 ☐ Never Married 2 X Marned Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Lieutenant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Dante Chicca Mamie Calazze 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) l Cutlass Dr., Berlin, Md. 21811 Stephanie Chicca (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. Cape Henlopen Crem. 4-6-2006 Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, Md. 21811 Part1. Enter the disease, or complications that clus-shock, or hear ailure. List only the cause on each I th. D not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Cerebrovascu Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of): The law requires thet the death certificate be executed ettending physicien and for use as the burial-transli Exam Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the e 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2000 3 ☐ Probably 4 ☐ Unknown 1 Tyes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificete has the lirector, page 2 s autopsy performed? 1 Yes 2 No 1 Yes PX No Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only ne Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🎾 No ဥ 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1X Natural М 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide in 24 hours.
the Funeral Directory 29a. Certifier XCX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ical and manner stated. within 2. To the ! 29d. Date signed (Month, Day, Year)

State Registrar

10+

APR 0 6 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

13007 Coastal Hwy., Suite 5, Ocean City, Md. 21842

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Jock Simon,

29c. License number

			State of Maryland / Department of Health and M Certificate of Death		Reg. No.	5 12300		
	Physici		1. Decedent's Name (First, Middle, Lest) MARY MAGALENE CUMM: NGS	2. Date of Dea Month	Day	Year 23. Time of Death		
>	/Medio Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Lo	cation of Deeth		1000		
			Edward UCCready Memorial Hospital Crisfiel 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs.		1	omerset		
ı	Funeral Director		339 - 64 - 0914 1□ M 2⊅F 93 Yrs. Months Deys Hours Min.	8. Date of Birth (Month, Dey 2 - 25 -	1912	9. Birthplace (State or Foreign Country) NORTH CARDINA		
	and		Usual Residence of Decedent 10a. State 10b. County 10c City, Town or Location			10d. Inside City Limits		
	Mary B-f sho	tor	MD Somerset Princess Anne			1 XYes 2 □ No		
	ith the	Direc	10e. Street and Number 10f. Zip Code	1	10g. Citizen of V	Vhat Country?		
	deeth v	eral	11. Marital Stetus 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Spenic Armed Forces?) 14. Was Decedent of Hispenic Origin? (Spenic Armed Forces?)	ecify Yes or No-	14. Race	e - American Indian,		
21215-0020	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No 1	Rican, etc.)	Specify	k, White, etc.		
15-0	n 72 h "natu edical	letec	15. Decedent's Education (Specify only highest grade completed) [Security only highest grade completed] [Security only highest grade completed] [Security only highest grade completed] [Security only highest grade completed]	ing	16b. Kind of Bu	siness/Industry		
212	d withi	ошо	Elementary/Secondary (0-12) College (1-4or 5+) Laborer		Home	maker		
	nould be filed withir I Mentel Hygiene. narked other than natic event, the M	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name CROEST Mc Neill 18. Mother's Name HORTE		Maiden Surnem	θ)		
Maryland	2 should and Men is marke eumatic	2	PRIEST Mc Neill 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Bura			State, Zip Code)		
	1 end 2 Health a em 27 is other treu		Grace DENNIS - Daughter 11601 Record have t)		e, UD 21853		
ore	Pages 1 nent of He int: If iten iry or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Plece of Disposition (Name of cernetery, crematory or other plece)			City or Town, State		
Baltimore,	permit. Pag Department Important: If any injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	4-09-2006		NORTH Caroling		
Ba	permit. Departn Importa any injt		Huthy E. Ward So 30639 Hampden Are.	Proposed t	tome	4D 2195=		
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac o shock, or heart failure. List only one cause on each line.	or respiratory err	est,	Approximate Interval Between		
)	Physician /Medical		Immediate Cause (Final			Onset and Death		
	Examiner		disease or condition resulting in death) Due to (or es a consequence ol):					
-	ted nsit	nlne	D					
oʻ	icate be executed physician end s the burial-transit	Aedical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of):					
68760,	cate be ohysici the bu	dical	Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of):					
Box 6	certific nding p use as	n/Me	d					
	death ne atter	Physician/	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did to	obacco use con	tribute to the cause of deeth?		
P.0	ires thet the death cert signed by the attendin d be detached for use	Phy		1 □ Y	es 2XNo	3 ☐ Probably 4 ☐ Unknown		
Records,	The law requires that the death certificate be executed ate has been signed by the attending physician end page 2 should be detached for use as the bunal-transit	ed by		24a. Was e		24b. Were autopsy findings		
eco	aw requir as been si 2 should	Completed		perfor	med?	available prior to completion of cause of death?		
al R	: The cate h			1 □ Y	es 2 Mio	1 ☐ Yes 2 ☐ No		
Vital	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No			or (Specify)		
n of	ng Phy ter this ineral o				ow injury occurre			
Division	Attending or death. ector: Afte by the func	cati	2 Accident investigation 3 Suicide 6 Could not be	28I. Location (S	treet and Numbe	er or Rural Route Number,		
Σ	al or A s after il Direc	building, etc. (Specify) City or Town, State)						
	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical (29a. Certifier (Check only one) 124 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, a 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, a 2 minute of manner stated.					
	ro the within ? To the comple	Med	29b. Signature and title of certifier 29c. License number	2	9d. Date signed	(Month, Day, Year)		
	,- > - 0	D54422 4-3-						
			30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 1604 - Market St., Po wwke, N	11) 2	1851			
1	Sta	te	31. Date filed (Month, Day, Year) 32. Registar's Signature					

State of Maryland / Department of Health and Mental Hygiene per FH G855 5/8/06 of Death

State of Maryland / Department of Health and Mental Hygiene per FH G855 5/8/06 of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Apr 15, 2006 **Physician** Year Dick Jane 03:55 am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany County Nursing Home Cumberland Allegany | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Jun 2, 1923 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔽 F Director 82 218-16-4912 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location r i ien "naturel", or items 23e or 28e-f show In Madical Examiner must be notified at 10d. Inside City Limits Allegany MD Cumberland 1 ☐XYes 2 ☐ No Direct 10e. Street and Number 11611 Olive Avenue SW 10f. Zip Code 10g. Citizen of What Country? Furnace Street Ext. 21502 USA filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: white Specify: ģ 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygierie.
Importent: It item 27 is marked other 4 ien "na eny injury or other treumatic event. Its Madic ance. Elementary/Secondary (0-12) College (1-4or 5+) iz Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Noah Gurtler Jane (Reed) Gurtler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21502 Robert Dick 11611 Olive Avenue Cumberland son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Rocky Gap Veterans Cemetery 4/20/2006 MD Flintstone ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Scarpelli Funeral Home, P.A. Oux 108 Virginia Avenue; Cumberland, MD 21502 23a. P. rt1. Enter the disease, or complications that cause the death. ock, or heart failure. List only one cause on each line. To not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DIABETES MELLITUI ONE TEAK /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Irijury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and ре ехесп Due to (or as a consequence of) Box 68760. Physician/Medical the as nding 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery alten 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) Records, P.O. the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ FIBRUSIC 1 Yes 2 No 3 Probably 4 Unknown Completed The law 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2√ No 2□ No 1 ☐ Yes 1 🗌 Yes Division of Vital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the within 24 hours after deat To the Funerel Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -14861 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robustiano Barrera M.D. Mem. Hosp Med Bldg Cumberland MD 21502 State Registrar

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Division of Vital Records, P.O. Box 68760,	To the Unenital or Attending Division. The law requires that the death conficusts he executed
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			1- State of Maryland / Department of Health a Certificate of Death	nd Menta	l Hygie Reg.	4000	12582					
*	Physici	_	Decedent's Name (First, Middle, Last) Domenick William DiFalco		of Death	9° 2006	3. Time of Death 8:40 PM					
	/Medic Examin	54	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of	Death		4c. County of Dea						
	***		Doctors Community Hospital Lanham 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2	4 Hrs. 8 Date	a of Birth	Prince (Georges					
	Funeral Director		210-24-6718 1 Months Days Hours	Min. Mar	ch 31,	9. Bi	Pennsylvania					
pur	3:00		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location				10d. Inside City Limits					
Manyla	ohs j	JO.	MD Prince Georges Bowie				1 XYes 2 No					
the I	r 28a- motifi	Director	10e. Street and Number 10f. Zip Code		10g.	Citizen of What C	country?					
th with	23a o	ai D	4509 Oaklyn Lane 20715			USA						
ours after dee	ir neatin and wental trygiene. Tright azz is marked other than "natural; or iteme 23s or 28s-f show other traumatic event, its Madical Examinar must be mollified at	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Narried 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 No Specify: 13. Was Decedent of Hispanic Origing If Yes, specify Cuban, Mexican, 1 Yes, Sive Year or Dates: 150-152	in? (Specify Ye Puerto Rican, e	s or No- etc.)	14. Race - Am Black, Wh Specify: W						
within 72 hc	sne. then "natur e Madical	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use righted) Assistant Commissioner for Railroad Health & Safety 16b. Kind of Business/Ir										
De la	other ent, II	a l	2 Railroad Health & So	arery 's Name (First,								
uld be	wenta irked itic ev	To B	Frank DiFolco Eliza	lano								
2 sho	is ma		19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and Number</i>				Zip Code)					
1 and	em 27 ther to		Frank J. DiFalco/ Son 7902 Oxfarm Court 20a. Method of Disposition 20b. Place of Disposition (Name of	Bowie,			r Town State					
Pages	Department of Health a fimportant: If Item 27 is eny injury or other tra		20a. Method of Disposition 1 Aburial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Calvary Cemetery April 3, 2006 Altoona, PA									
permit	impor eny in	6 3	21. Signature of Funeral Service License 22. Name and Address of Facility 16000 Annapolis									
· /N	ysician Medical aminer		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as c shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Failur	,		Approximate fnterval Between Onset and Death					
icate be executed	ettending physicien end for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Fine I Indextyling.	reing	mq							
Or Vision of Vis	y the ached	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetaf death 3 Ectopic pregnancy 5 Other (specify)			23d. Date of de Month	elivery Day Year					
quires tha	sign d b	ρ	Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	236	e. Did tobace		to the cause of death?					
The law re	has Je 2	Completed			a. Was an autopsy performed Yes 2 D	prior to death?						
sician	certificate irector, pag	o Be	examiner?	of Death (Check		. 72.						
g Phy	erthis eraldi	\vdash	27. Manne it Death 28a. Date of Injury 28b. Time of 28c. Injury at			e 6 □Other (Speniury occurred	ecity)					
ng d	or: After	atio	2 Accident investigation M 1 Yes 2 N	lo								
al or Att	N Director: od in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f Loc City	ation (Street or Town, S	t and Number or F tate)	lural Route Number,					
he Hospit	within 24 hours arief death. To the Funeral Director: A completely filled in by the fu	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.	place, and due	to the cause time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)					
Tot	To 1	×	29b. Signature and title of certifier D60611		29d.	Date signed (Mon	th, Day, Year)					
			30. Name and address of person who completed cause of death (flene 23a) (Type, Print) 8118 Good Luck Ro	oad Lar	nham,	MD 20706						
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 4 2006 32. Projector's Signature									

DHMH 17 Rev 1/2001

			For	State of Marylan				Mental Hy	giene	116	12583	3
			1 - State Registrar 1. Decedent's Name (First, Middle, L.	oct	Cert	ificate of L	Death	2. Date of De	Reg. No.		3. Time of De	
2	Physici		BEILLAN M	DESMIELD	15			Month	Day	Year O6	1:25	
	/Medic Examin		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, or	Location of Dea	ath 7	4c.	County of Death	4	
4			MANOKIN 5. Social Security Number 6.	Sex 7. Age (In yrs.	last birthday)	If Under 1 Year	ESS 1 If Under 24 Hi		th	DOME!	RSET place (State or Fi	Oreian
	Funeral Director			1□ M 2 XF 93	Yrs.	Months Days	Hours Mi	n. (Month, D.	ay, Year)	Cou	MD)
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Loca	ation					10d. Inside City L	Limits
	Mary B-f eh	tor	MD Some	ERSET L) EST	DUER					1 ☐ Yes 2	No
	or 28	Direc	10e. Street and Number	$\overline{\mathcal{D}}$		10f. Zip Code	7 (7)	-	10g. Citi	zen of What Cou	_	
	heath v	Funeral Director	3108/- 108KE	12. Was Decedent Ever in U	.s. 13. W	as Decedent of His	spanic Origin?	Specify Yes or No)-	U 5 f	•	
9	or Iter	, Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ★ No If Yes, Give	lf '	Yes, specify Cubar ☐ Yes 2 No	n, Mexican, Pue Specify:	erto Rican, etc.)		Black, White,		
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Iteme 23a or 28a-1 ehow ther than "natural", or Iteme 23a or 28a-1 ehow ant, the Medical Examiner must be incitilled at	ed by	3 Widowed 4 ☐ Divorced 15. Decedent's 8	Year or Dates:		nt's Usual Occupa			16h Ki	nd of Business/Ir	LACK	
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Maryland	perriat. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other traumatic event, the Medical Experiment and the indifficit	To Be	17. Father's Name (First, Middle, Las	COLLINS				ame (First, Middle ZABET		FOOK	<	
ary	and M and M s mar	-	19a. Informant's Name/Relationship		19b. Mailing	Address (Street a		Rural Route Numb		r Town, State, Zi	Code)	
	1 and 1 Health In 27		JEAN WHITINGTON 20a. Method of Disposition	DAUGHTER 200 F	3576 Place of Disposi	GREEN Name of	HILL	ANE WE	STAY	Cation - City or T		71
nor	ages ant of h nt: If ite y or of		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	□Removal from State, °	semetery, crema	S CH, CE	1 .	8-06	1			
Baltimore,	permit. P Departme Importan any injur		21. Signature of Filheral Service Lice			Name and Addres		BENNIE			FIH	
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	į,		23a. Part1. Enter the disease, or con shock, or heart failure. List ont Immediate Cause (Final	nplications that caused the deat y one cause on each line.		,			rrest, '		Approximate Interval Betwee Onset and Dea	en ath
Ŋ.	Physician /Medical		disease or condition resulting in death)	a Due to (or as a conseq	Lnd Si	tage re	not an	scare			34cm	-5
ž.	Examiner	L.	Sequentially list conditions.	b		A	KOND				loyear	N
	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence or):							
Ö,	sician and burial-transit		that initiated events resulting in death) Last	Due to (or as a conseq	uence of):							
8760,	icate be ex physician s the buria	dicai	•	d						-		
ŏ	eath certific ettending pl	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					2	23d. Date of deliv	ery	
P.O. Box 6	Attending Physician: The law requires that the death certificate be executed rideath. rideath. sctor: Atter this certificate hes been signed by the ettending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Mec	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time of d		ctopic pregnancy Other (specify)				Month	Day Yea	ır
_	signed by		Part II. Other significant conditions	contributing to death but not res	ulting in the und	dertying cause give	en in Part I.	23e. Did	obacco u	se contribute to 1	he cause of deat	th?
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Division of Vital Records,	e law re hes be je 2 sho	Completed						24a. Was	psv	24b. Were auto	opsy findings ava	allable se of
E E	ysician: The is certificete hi director, page	e Cor	25. Was case referred to medical				OC Blace of D	1 Yes	2 No	death?	2□No	
<u></u>	nysicla	To B	examiner? 1 □ Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3□ DOA Othe		eath (Check only Home 5 Res		5 ☐Other (Speci	(y)	
0 00	ding Phy h. Alter the		27. Mapmer of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe	how injur	y occurred		
Visio	Attender death	Certification:	2 Accident investigate 3 Suicide 6 Could not determine	be 28e. Place of Injury - At he	ome, farm, stree		/es 2□No	28f. Location	Street an	d Number or Rur	al Route Number	r,
۵	irs afte		4 Homicide determine	building, etc. (Specif				City or To				
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certifying F (Check only 2 Medical Exa	hysician: To the best of my kno iminer: On the basis of examina and manner stated.	wledge, death oution and/or inve	occurred at the time estigation, in my op	e, date and pla- pinion, death oc	ce, and due to the curred at the time,	cause(s) date and	and manner as s place, and due t	tated. o the cause(s)	
	To the within To the compl	Me	29b. Signature and title of certifier			29c. License	number		A	e signed (Month,		
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			30. Name and address of person who	completed cause of death (Item	n 23a) (Type, Pi くろ・カルル	rint)	SALISB	ury 1	4027	onil 41.		
75	Sta		31. Date filed (Month, Day, Year)	76, AN 1415 32. Pigistrar's Signa 2006	ature			/				
4	Registr	ar	APR U7	LUUB Breeze	II An	selle)						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2006 8:02 p Physician Emerson George Oliver April 2, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Sandy Spring Friends Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth Manths Days Hours Min. May 1991 2 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Months Virginia 15M 20F 93 Yrs. 224-52-8112 Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location the Maryland 10a. State 10b. County or 28a-f show 1 ☐ Yes 2 ▼ No Olney Directo Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20832 2712 Covered Wagon Way death Funera 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 naturel', or Spec White If Yes, Give Year or Dates: 1945-66 þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Medical Physician permit. Pages 1 and 2 should be filed wit Depertment of Health and Mental Hygiens Important: If item 27 ie marked other the eny injury or other traumatic event, the onget. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Laura Martha Fulton George Oliver Emerson, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Virginia F. Emerson/ Wife 2712 Covered Wagon Way, Olney, MD 20832 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition April 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Alexandria, Virginia Metropolitan Crematory 2006 4 ☐ Donation 5 ☐ Other (Specify) Francis Addes Collins Funeral Home Inc 21. Signature of Funeral Service Licens 500 University Blvd, W, Silver Spring, MD 20901 noblei 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pneumonia resulting in death) Due to (or as a consequence of): Congestive Heart Failure /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examiner Critical Aortic Stenosis The law requires that the death certificate be executed buriai-trar resulting in death) Last Due to (or as a consequence of) Box 68760, Completed by Physician/Medical as the l IF FEMALE esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy ned by the atten detached for u Month Day 5 Cther (specify) 1 ☐ Yes 2 ☐ No P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 8 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital To the Hospital or Attending Physicien: 26. Place of Death (Check only one) director, 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 7 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: Injury 5 Pendina 1 XNatural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L Tertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 025947 5+1 o completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 5540 TEN OAKS RD., CLARKSVILLE, MD 21029 JACKSON, MD.

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] State
RegistravEND#23a(c)perMD4/7/06,EMW,McCo Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year March 28, Grace Flenoy 2006 4:00 AM^M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□M 2 F 433-24-9410 87 1918 Louisiana Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No D.C. N/A Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2152 Newport Place, N.W. 20037 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩNo If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 XNever Married 2 Married 1 ☐ Yes 2 A No Specify: Black Specify: 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Coflege (1-4or 5+) Clerk Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Clem Flenoy Maggie Creswell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Varrone (conservator) 910 17th St. N.W. Suite 800, Washington, D.C. 20006 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 X Removal from State Union Cemetery 4/8/06 4 ☐ Donation 5 ☐ Other (Specify) Mansfield, Louisiana 22. Name and Address of Facility McGuire Funeral Service 21. Signature of Funeral Service Licensee 7400 Georgia Ave. N.W., Washington, D.C. pason 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death A CUTE respiratory arest 1 minute Due to (or as a consequence of): Acute renal tallure 1 day Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events in the coulting in the cause of Due to (or as a consequence of): Pneuronia resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Pneumonia 1 ☐ Yes 2 ☐ No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death | Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

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Funeral

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other then "naturel", or iteme 23a or 28a-f ehow vent, the Medical Examiner must be notified at

ulth and Mental Hygie 27 is marked other r traumatic event, II

Department of Health a Important: if item 27 le any njury or other traugonce.

the Maryland

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

physicien and s the burial-transit Exami use as alten for u ed by the a been si should b certificete Medical Certification: To Be Ė this

Physician/Medicai Completed by

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral To the !

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Natural 28a. Date of Injury (Month, Day Year) 2 Accident

5 Pending investigation 6 Could not be determined 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death uncurred at the time, date and place, and due to the cause(s) and manner ac etated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

DOP 63129

29c. License number

29d. Date signed (Month, Day, Year) MARCH 28, 2006

se of death (ftem 23a) (Type, Print)

9901 Medical Center, Rock. MD

State Registrar 31. Date filed (Month, Day, Year) 07 5008

			1 - State Registrar	Maryland / Depa		of Health and of Death		Reg. No.	06	12586
à	Physici /Medio		1. Decedent's Name (First, Middle, Last) Estella Stackenwalt Feather		,		2. Date of De Month April	Day 4	2006	3. Time of Death 10:30 P M
	Examir Funeral	er	4a. Facility Name (If not institution, give street and number Heritage Harbour Health & 5. Social Security Number 6. Sex 7.	*	If Under 1		s. 8. Date of Bi	i	County of Dead	
4	Director		Usual Residence of Decedent	98 Yrs.		Days Hours Mi	July 2	2, 19		w Jersey
	th the Maryla or 28a-1 shov e notified at	Olrector	Maryland Anne Arundel 10e. Street and Number	10c. City, Town or Lo		ode		10g. Citiz	en of What Co	10d. Inside City Limits 1 ☐ Yes 2 🛣 No puntry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-1 show any highry or other traumatic event, the Medical Exerciting I. Just be invitibled at ODGs.	by Funeral Directo	151 Island View Road 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decede Armed Force 1 1 Yes 2 If Yes, Give	s? X No	214 Was Deceder If Yes, specify	nt of Hispanic Origin? (Cuban, Mexican, Pue		Unite	es encan Indian, e, etc. White	
21215-0036	ed within 72 ho giene. er then "netur i, the Medical I	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4c)	(Give	dent's Usual C kind of work DO NOT use Home	done during most of w retired)	orking		d of Business	,
Maryland	should be file and Mental Hy marked oth umatic event	To Be (17. Father's Name (First, Middle, Last) John Valentine Stackenwalt 19a. Informant's Name/Relationship (Type, Print)		ng Address (S	18. Mother's Na Sara Llc Street and Number or F				Zip Code)
altimore, M	Pages 1 and 2 tent of Health (int: If Item 27 i		Margaret F. Panetti / Daug 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from Sta 4 Donation 5 Other (Specify)	20b. Place of Dispo	sition (Name natory or othe	r place)	Date	20c. Loc	ation - City or	
Balti	permit. Departm Importa any Inju		21. Signature of Funefal Service Licensee		147 Dul	Address of Facility	John M. Sester S	Tay lo	r Fune:	ral Home, Inc.
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each Immediate Cause (final disease or condition resulting in death) Due to for Sequentially list conditions.	ı line.	er the mode of		ac or respiratory a	rrest,		Approximate Interval Between Onset and Death May 90005
8760,	rate be executed thysicien and the burial-transit	Ilcal Examiner	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	as a consequence of):						
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	w requires that been signed to should be deta	þ	Part II. Other significant conditions contributing to death	n but not resulting in the ur	nderlying caus	se given in Part I.		obacco use Yes 2 🗆		the cause of death?
al Reco		e Completed	25. Was case referred to medical						prior to death?	topsy findings available completion of cause of
Division of Vital Records,	25. Was case referred to medical sexaminer? 1							Sify)		
DIVIS	i Pite	Certification:	4 Homicide Statistics building,	Injury - At home, farm, streetc. (Specify)			City or To	wn, State)		ral Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one) 2	s of examination and/or inv	estigation, in	he time, date and place my opinion, death occ icense number	e, and due to the urred at the time,	date and p	lace, and due	to the cause(s)
)	¥ 3 7 8		30. Name and address of person who completed cause of	MD.	I		Glen	41	signed (Month) Day, (edi)
2	Sta	te.	Mirge M. Nuscilee,	strar's Signature	di son	Park,	Glen	Sur	rie,	2/06/
	Registr	_	APR 0 6 2006	w It for	M.					

06-02458 Fischer, Kirk	S 1- For State Registrar	Please T tate of Maryland	l / Departr	ment of icate of	Health an	elible Ink id Mental Hy	rgiene Reg.	No. 2006	12587	
Physician/ Medical Examiner	Decedent's Name (First, Middle Kirk Stephe:							ay Year	3. Time of Death	
$\overline{}$	4a. Facility Name (if not instituti 600 Block Woodsma	on, give street and numbe	r)		. City, Town, or Annapolis	Location of Death	April 10, 200	4c. County of Dea	ath	
Funeral Director	5. Social Security Number 148–44–5946	6. Sex 7. A	ge (In yrs last b	oirthday) Yrs.	If Under 1 Year Months Day		8 Date of Birth (MM/DD/YYYY) 9. E	Birthplace (State or Foreig Country) WI	
ĥ.	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location	1				10d. Inside City Limits	
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tith the Maryland 23a or 28a-f show any notified at once. al Director	10e. Street and Number 1796 Bay Ridge	e			10f. Zip Code 214(10g	Citizen of What Co	ountry?	
death with r items 23 nust be no	11 Marital Status 1 XNever Married 2 N	12. Was Deceder Armed Forces 1 Yes		13. Was	Decedent of His , specify Cubar	spanic Origin? (Spe n, Mexican, Puerto F	ecify Yes or No- Rican, etc.)	14. Race - Ame White, etc.	erican Indian, Black,	
s after ral", o		vorced If Yes, Give Year or Dates:			es 2 X No			Specify:	White	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	15. Decedent's Education (Spe Elementary/Secondary (0-12)		duri	ng	ent's Usual Occupation (Give kind of work done of working life. DO NOT use retired) N/A			6b. Kind of Busines:	s/Industry	
5-00 led with tygien other the Me	17. Father's Name (First, Middle	e, Last)			,	18.Mother's Name (First, Middle, Maid			
2121 Ild be fi Wental I marked event,	Emil Fischer						n Fische			
AD 2 2 should 1 and M 27 is m matic	19a. Informant's Name/Relations Gregory W. F.					et and Number or Ru E Lane, Di		Number, City or Town, State, Zip Code) NC 27705		
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than njury or other traumatic event, the Medica To Be Comple	20a Method of Disposition 1 Burial 2 X Crematio	n 3 Removal from S	20b. Place		on (Name of cer	netery, Apr.	Date 20	Oc. Location - City of Baltimore		
ultim nit Pa artmen oortant	4 Donation 5 Other S 21. Signature of Juneral Service				ne and Address		2006	Datchiole	:, PID	
Physician /Medical Examiner	failure. List only one cause Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b on each line. a Drowning C Due to (or as a const Due to (or as a const Due to (or as a const	omplicate sequence of):		the mode of dying, such as cardiac or respiratory arr				Approximate Interval Between Onset and Death	
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execution at the funeral Director: After this certificate has been signed by the attending physician at completely filled in by the funeral director, page 2 should be detached for use as the burial edical Certification: To Be Completed by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Un	4 Pregnant a	me of pregnanc	2 Fetal	death 3	Ectopic pregnand		23d Date of delive Month	ry Day Y ear	
P.O. Is that the gned by the detacher	Part II. Other significant condit	tions contributing to dea	th but not resulti	ing in the und	lerlying cause g	iven in Part I.	23e. Did tobac	co use contribute to	the cause of death?	
Records, P : The law requires the ficate has been signed, page 2 should be d Completed b	Schizophrenia	; Hypertensive	cardiovas	cular d	isease		1 Yes 2 24a Was an autopsy performed	24b. Were a	obably 4 Unknown utopsy findings available completion of cause of	
I Re n: The tificate or, pag	25. Was case referred to medica	ı			OC Die ee	of Dooth (Charles	1 ✓ Yes 2	No 1 🗸	es 2 No	
Vital ysician this certi directo	examiner?	Hospital: 1 Inpati	ent 2 ER/0	Outpatient 3		of Death (Check on Other Nursing		sidence 6 🗸 Othe	er: Scene	
Division of Vital Records, To the Hospital or Attending Physician: The law requirements after death. To the Funeral Director: After this certificate has been scompletely filled in by the funeral director, page 2 should edical Certification: To Be Complete	27. Manner of Death 1 Natural 5 Pend	28a Date of Inj (Month, Day) ding stigation Fnd 4/10		. Time of Inju	Injury 28c. Injury at Work? 28d De			injury occurred		
Division o spital or Attending hours after death. neral Director: Afte filled in by the fune Certification:	Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) found in stream 28f. Location (Street and Number or Rura or Town, State) OB Block V							ural Route Number, City Woodsman Way		
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the 1	one) 2 Medical Exa	hysician: To the best of n iminer:On the basis of exa and manner stated	mination and/or	eath occurred investigation	d at the time, da i, in my opinion	te and place, and du	ue to the cause(s)	and manner as sta	rted.	
Ž	29b. Signature and title of certifie	er			29c License			d. Date signed (Mo	onth, Day, Year)	
	-/////	11 1/-			O.C.	VI.C.	Α	pril 11, 2006		

State Registrar



State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)

Ruth Louise Fisher

2588

8 A.

3. Time of Death

Reg. No.

5 Day 200 6 ear

2. Date of Death Apr • 5

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) E.	xaminer
Fu	neral

7	Examir	_	4a. Facility Name (/	f not institution, giv	e street and nu	m <i>ber</i>)			or Location of Dea	uth	40	. County of Dea	
			Citiz	ens Nur	sing H	Iome			erick			Frede	
	Funeral Director		5. Social Security N 219-20-		Sex I∐M 2.527 F	7. Age (In yrs. 78	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		rth ay.2/547	1928	thplace (State or Foreign MD
	D		Usual Residence of			7							T
	Marylan	tor	10a. State MD	10b. County Fred	lerick	10c. Cit	y, Town or Loc Midd	lletown					10d. Inside City Limit
	with the	Funeral Director	10e. Street and Nut	_{mber} Hawbott	om Rd.	•		10f. Zip Code	1769		10g. Ci	USA	ountry?
	death me 2;	nera	11. Marital Status		12. Was Deci	edent Ever in U	.S. 13. V	Vas Decedent of H Yes, specify Cub	Hispanic Origin? (Specify Yes or N	0-	14. Race - Ame	
21215-0036	be filed within 72 hours after death with the Maryland lat Hygiene. d other then "natural", or iteme 23s or 28s-1 show event, the Medical Evaluation must be nytified at	þ	1 ☐ Never Marr 3 X Widowed	ied 2☐ Marned 4☐ Divorced	1 Tes If Yes, Gir Year or D	2√∆ €\0 ve		Yes 2 No		nto rican, etc.)		Black, Whi	
5-0	72 hc natur	eted	(Spec	15. Decedent's E cify only highest gr	ducation ade completed)		16a. Deced	ent's Usual Occup kind of work done OO NOT use retire	oation during most of w	orking	16b. K	and of Business	/Industry
121	within ene. then "	Completed	Elementary/Seco	ondary (0-12)	College (1-4or 5+)		opera opera			opt	cical (20.
	should be filed within of Mental Hygiene. marked other then imatic event, the Mi	Be	17. Father's Name			s		. 07020	18. Mother's Na	ame (First, Middle	, Maider		
Maryland	2 2 2 2	To	19a. Informant's N	ame/Relationship (Type, Print)			g Address (Street					Zip Code) MD 21769
Baltimore,			20a. Method of Dia		Removal from	Ctota	Place of Dispos cemetery, crem	sition (Name of natory or other pla	сө)	Date 3/06	20c. L	ocation - City or	Town, State
Baltii	permit. Pege Depertment of Important: If eny Injury or once.		21. Signature of Fu		Prisee C		²²	Name and Addre Onald 31 E. M	B. Thomain St.	npson F	une: let	ral Hon	me D 21769
	Physician		Immediate Cause	the disease, or com art failure. List only (Final	one cause on e	caused the deat							Approximate Interval Between Onset and Death
	/Medical Examiner	8	disease or condition resulting in death)	•	aDue to	(or as a conseq	uence of):						-
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oʻ	eath certificate be executed attending physicien and for use as the burial-transit	Examiner	Cause (Disease or that initiated events resulting in death)	injury	c	(or as a conseq	guence of):						
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0	ding Phys th. After this funeral di		27. Manner of Dear			of Injury oth, Day Year)	28b. Time of Injury	28c. Inju Wo		28d. Describe			
sior	Attending or death.	catic	1 Natural 2 Accident	5 Pending investigation	n		,		Yes 2 □ No				
Divi	s after de Direct	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	289. Place	e of Injury - At hing, etc. (Specil	om e, fa rm, stre fy)	eet, factory, office		28f. Location City or To	(Street a. own, Stat	nd Number or R e)	ural Route Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edicai	29a. Certifier (Check only one)	1☐ Certifying P 2☐ Medical Exa	miner: On the b	e best of my kno pasis of examina iner stated.	owledge, death ation and/or inv	occurred at the ti restigation, in my	me, date and place opinion, death occ	ce, and due to the curred at the time	cause(s , date an) and manner a d place, and du	s stated, e to the cause(s)
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State of Maryland / Department of Health and Mental Hygiene For State Ragistrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician 4 _ 6:15 Am 2006 April LEROY R. FOSTER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Casey House If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months 1**3€134**0 2□ F 416-92-7278 43 Nov 8,1962 Alabama Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a State 10h County ul Hygiene. . other than "natural", or iteme 23a or 28a-f ehow vent, itra Medical Examinar must be notified at 1 Yes 2 No Silver Spring Md Montgomery Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 531 Randolph Rd #209-B 20904 U.S.A. Completed by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 □ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Yrs Insurance Co. Insurance Agent or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important; if Itam 27 is marked othe eny lolury or other traumatic event once. Be Juanita Lee ၉ Leroy Foster Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Michelle Lee (sister) 607 Treecrest Parkway, Decatur, Ga. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate Of Heaven Cem 4/10/06 Silver Spring, Md 21. Sign, ture of Funeral Service Ligen, ee ²²Showdens Funeral Home P.A. 20850 246 N. Washingtpn St, ROckville, Md Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailule. List only one cause on each line. Immediate Cause (Final **Physician** HODGKINS LYMPHOMA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examinet Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner physicien and s the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Completed by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Tetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an 2 X No 1 ☐ Yes certificate Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 (2)Other (Specify) Hospice Hospital: 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ this After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 27. Manner of Death 1 Natural s after dea. 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide within 24 hours a

To the Funeral C

completely filled i 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10 D-35635 April 5, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Kaplan 6001 Muncaster Mill Rd, Rockville, Md 20855 \mathtt{Dr} 31. Date filed (Month, Day, Year) APR 0.6 32/Registrar's Signature State 06 2006 Registrar

			For State Registrar	State of Marylar		nt of Health and I te of Death	Mental Hygier	2006 125911
	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last)	L. tie	lds u) _Y .	2. Date of Death	Day Year 3. Time of Death 9, 2006 0905 M
	Examin Funeral Director		4a. Eacility Name, (If not institution, give: OASTAL HOS 5. Social Security Number 2 15 - 62 - 0760	pice at the	clake	y, Town or Location of Death	8. Date of Birth	4c. County of Death WICOMICO 9. Birthplace (State or Foreign Country) MD
	e Maryland	ctor	Usual Residence of Decedent 10a. State 10b. County	PSET 10c. CI	ty, Town or Location LRISFIEII	>		10d. Inside City Limits 1 (\$2 Yes 2 ☐ No
	ath with th 23a or 26 ust be no	Funeral Director	26244 PLum.			21817		Citizen of What Country? U.S. A
980	hours after death with the Maryland turat', or ttems 23a or 28a-f show at Expriner must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ② Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	J.S. 13. Was Dec If Yes, sp 1 ☐ Yes	edent of Hispanic Origin? (S ecrify Cuban, Mexican, Puerl 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK
21215-0036	within 72 ane. than "na	Completed	15. Decedent's Edu (Specify only highest grad	cation a completed) College (1-4or 5+)	16a. Decedent's Us (Give kind of w life. DO NOT	ual Occupation rork done during most of wo use retired) WORKER	rking	. Kind of Business/Industry STALL OF Longelicut
aryland	should be filed on the marked other imarked other imatic event.	To Be C	17. Father's Name (First, Middle, Last) Robert Field	5		18. Mother's Nac	ne (First, Middle, Maid	den Sumame) VENS
Σ	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke any injury or other traumatic <u>once</u> .		19a. Informant's Name/Relationship (Ty Howard Traver	5 - Farend	P.O. 30	× 2797	Salisbury	ty or Town, State, Zip Code) Z 1 SO Z
altimore,	Pages 1: nent of He ant: If Iten ary or oth		20a. Method of Disposition 1 Burial 2 Coremation 3 F 4 Donation 5 Other (Specify)	Removal from State	Place of Disposition (No cometery, crematory or CVEV	ame of other place)	Date 200	. Location - City or Town, State
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens	Vall	22, Name 306	and Address of Facility Dony & Wall 19 Hampaen A	Funeral Ho Ve. Princes	me Anne, MD 21853
	Physician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only o Immediate Cause (Final disease or condition	ications that caused the dea ne cause of each line. ACOUIRED		ode of dying, such as cardia		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Sequentially list conditions,	Due to (or as a consec	quence of):		,	
3760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the ettending physician and rail director, page 2 should be detached for use as the burial-transit	I Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consect. Due to (or as a consect.				
õ	ertificate t ding physic se as the b	Medical	IF FEMALE:	d. 23c. If yas, outcome of pregn	ancy.			and Dave at delivery
P.O. Box	that the death certific ed by the ettending p detached for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fet: 4 ☐ Pregnant at time of 6 9 ☐ Unknown	al death 3 □Ectopic			23d. Date of delivery Month Day Year
	w requires that been signed b should be deta	٥	Part II. Other significant conditions co	ntributing to death but not re	sulting in the underlying	g cause given in Part I.	23e. Did tobac 1 ☐ Yes	co use contribute to the cause of death?
l Reco	The law requate has been page 2 should	Completed					24a. Was an autopsy performed	
/ita	cian: ertific actor,	Be	25. Was case referred to medical examiner?	In-a-hali			ath (Check only one)	
Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: Atter this certificate has completely filled in by the funeral director, page 2	မ	1 Yes 2 XNo 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Propatient 2 [28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	OOA Other: 4 Nursing I	dome 5 Residence 28d. Describe how	e 6 Other (Specify) njury occurred
Divis	al or Atter s after dea al Director ad in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, factify)	ory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number. tate)
	To the Hospital within 24 hours a To the Funeral completely filled	edical (sician: To the best of my kn iner: On the basis of examin and manner stated.				e(s) and manner as stated. and place, and due to the cause(s)
	To the vithin 2 To the comple	Me	29b. Signature and title of certifier		2	29c. License number		Date signed (Month, Day, Year)
			150	22	n	D00584	10	4/8/06
			30. Name and address of person who co	s 26266	m 23a) (Type, Print) ARADWW	ODD UT.	SALISI	BURY MD 2/80/
	Sta Regist	ate rar	3Y. Date filed (Month, Day, Year) APR 1 0	32. Registar's Sign	nature	ale .		BURY MD 2180)

DHMH 17 Rev 1/2001

ORIGINAL.

Timothy Ross Foskey
06-02284 Please Type or Print in Black Indelible Ink Unk, Unk State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death Physician/ Decedent's Name (First, Middle,Last) 3 Time of Death Month Da April 2, 2006 8:34PM Medical Examiner Ross IMOTHY ROSS 1-(
lity Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Peninsula Regional Hospital Salisbury Wicomico If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Director 213-708417 48 01-07-1958 1 **⋈**M MD Usual Residence of Decedent 10d. Inside City Limits any 10a. State 10c. City, Town or Location 1 X Yes 2 No DELMAR MD notified at once. WICOMICO hours after death with the Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1209 WALNUT 218 75 USA items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black permit. Pages I and 2 should be filed within 72 hours after death wi Department of Health and Mental Hygiene. Important: I fitem 27 is marked other than "natural", or items: injury or other tranmaric event, the Medical Examiner must be. Armed Forces? 1 Never Married 2 Married 2 X No Yes Specify: WHITE Widowed Divorced If Yes, Give Year 1 Yes 2 No specify. ò or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry most of working life. DO NOT use retired) MD 21215-0036 PLUMBING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM WASHINGTON FOSKE
19a. Informant's Name/Relationship (Type, Print)
19b. SOHNSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY PATRICIA CHAPMAN SISTET PO BOX 367 PITTS VILLE, MD 20a. Method of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore. crematory or other place) Burial 2 Cremation 3 Removal from State SAUS BURY CIZEMATORY 4-8-06 4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee JAL HOME PO BOX GI BIVALVE MD 23a. Part I. Enter the Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical a. Multiple Injuries Death Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and transit Physician/Medical UNPENDED **AMENDED** attending physician or use as the burial The law requires that the death certificate be Box 68760, IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 23d Date of delivery 1 Live birth Ectopic pregnancy Month Day Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknowr 23e. Did tobacco use contribute to the cause of death? Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 ✔ No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? 1 **✓** Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Division of Vital examiner? Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other 2 ER/Outpatient 3 V DOA 1 V Yes 28a. Date of Injury (Month, Day, Year) Apr 2, 2006 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 8:00:00 PM Pedestrian struck by auto Natural Yes 2 V No 5 Pending 2 🗸 Accident Investigation 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State)
Rt. 13 South, Salisbury, Md. determined (Specify) Local Street Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. April 3, 2006

31. Date filed (Mor. APR 07 State Registrar

Carol Allan, MD

30. Name and address of person who completed cause of death (Item 23a)

2006

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 1600 **Physician** 3 2004 29 Robert Lee Grim /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner WICHMICO CENTER 5PH 188UN KEGIONDI PENINSULA If Under 1 Year | If Under 24 Min 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours 1**X** M 2□ F 11-25-1928 232-34-2331 West Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or than "natural", or itema 23a or 28a-f show the Medical Examinar must be notified at Laure1 1 ☐ Yes 2 No DE Sussex Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 11390 County Seat HWY 19956 USA Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 □XYes 2 □ No If Yes, Give Year or Dates:1 951 1 Never Married 2 Married 1 ☐ Yes 2√☐ No Specify: Baltimore, Maryland 21215-0036 Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Sheet Metal Technician Heating/Air Company 18. Mother's Name (First, Middle, Maiden Surname) traumatic event, 17. Father's Name (First, Middle, Last) Be nd Mental marked o Francis Linkous Robert Lee Grim, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Juanita Grim (wife) 11390 County Seat HWY Laurel, De. 19956 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Department of H
Important: If Ite
sny injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Spring Hill MEM Gardens 4-3-2006 Hebron, Maryland 22. Name and Address of Facility
Hannigan-Short-Disharoon F.H. 21. Signature of Funeral Service Licensee Hannigan-Short—

700 West St. Laurel, De. 19956

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) week Physician preumoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine physicien and sthe burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? accident 2. No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Squamous autopsy performed? 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No မှ this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After 1 Natural 5 Pending investigation s after dea...ral Director: Aftr 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical сопревену 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30/06

State Registrar

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31. Date filed (Month, Day, Year)

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B.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Silvia

32. Registrar's Signature

Ir. mo

Penintula Keginnal

Medical

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 4:30 AM Gluck Donald 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Harford Memoria Hartord Hospita Harre de Grace If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 11 M 2 □ F Yrs. PΑ Director 207-22-0925 Usual Residence of Deceden death with the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiene.
ent: If Item 27 is marked other than "natural", or Items 23a or 28a-f ehow ury or other traumatic event, the Medical Examinal must be inclitted at 1

Yes 2 □ No Director Franklin Mercersburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 17236 USA 108 Faust Street Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ■Yes 2 □ No
If Yes, Give
Year or Dates: 1950-53 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4or 5+) Auto Assembly line worker 12 Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Beulah Gardner James E. Gluck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2754 Parallel Path, Abingdon, MD 21009 Robert H. Gluck/son timore. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) April 15, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Spring Grove Cemetery Lemasters, PA 2006 21. Signature of Funda Service Licensee 22. Name and Address of Facility Lininger-Fries Funeral Home Inc. 47 N. Park Ave., Mercersburg, PA ues Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner nheim Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or a - a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Completed by Physician/Medical Box 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the at id be detached for Ö 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 40 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed certificate 2 ANO 1 ☐ Yes of Vital To the Hospital or Attending Physician: director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 € 100 1 Depatient 2 2 ER/Outpatient 3 DOA this After this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cayse of death (Item 23a) (Type, Print) ee deen 31. Date filed (Month, Day, Year) gistrar's Signature State 1 2006 Registrar

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			1 - For State Registrar	State of Marylan			nt of Heal te of Dea			Reg. No	UUU	12594
	Physici	an	Decedent's Name (First, Middle, La						2. Date of De Month	aath Day	y Year	3. Time of Death
	/Medic		Vaughn Kirk Goodw						April		3 2006	
1	Examin	er	4a. Facility Name (If not institution, given Fairhaven	e street and number)		·	, Town, or Loca				County of Deat	n
			5. Social Security Number 6. S	ex 7. Age (In yrs.	last birthdav)		esville	nder 24 Hrs.	8. Date of Bi	rth	arroll 9. Birti	hplace (State or Foreign
ш	Funeral Director		505-12-6495	¥ M 2□F 91	Yrs.	Months	Days Ho	urs Min.	(Month, Da	ay, Year) 18 1	1914 Col	hplace (State or Foreign untry)
	D .		Usual Residence of Decedent							-	72 11 002	
	anylar show	Ļ	10a. State 10b. County	10c. Cit	y, Town or Lo	cation						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	Ba-f	cto	Maryland Freder	rick Mye	rsvill				ı			
	with the	吉	10e. Street and Number	1			p Code			_	izen of What Co	
	eath	erai	11191 Easterday R	12. Was Decedent Ever in U	S 13 1	217		ic Origin? (Sr	pecify Yes or N		ed Stat	
"	Iter d	Funeral Director	1 Never Married 2 Married	Armed Forces?	39-				pecify Yes or No Rican, etc.)		Black, White	
93	el', o	þ	3 \ Widowed 4 □ Divorced	If Yes, Give Year or Dates: 10	66	1 🗆 Yes	2∏ No Spe	ecify:			Specify: W	hite
21215-0036	72 hours after death with the Maryland Insturet; or Items 23e or 28e-f show dical Exeminer must be notified at	Completed	15. Decedent's Education (Specify only highest gra	ducation	16a. Dece	dent's Usi	ual Occupation onk done during use retired)	most of wor	kina	16b. K	ind of Business/	Industry
2	within ene. than "	mple	Elementary/Secondary (0-12)	College (1-4or 5+)								
121	filed withi Hygiene. othar than		17. Father's Name (First, Middle, Last,	4	Lt. C	olon		Mother's Nam	ie (First, Middle		Force	
Maryland		Be	Volney Walker Goo					atilda		, maiden	Sumame	
7	2 should be and Mental is marked eumatic ev	ဂ္	19a. Informant's Name/Relationship (19b. Mailir	ng Addres				er, City o	r Town, State, Z	(ip Code)
Ma	and 2 : ealth ar n 27 is nar treu		John Goodwin / So	n	933 G	rand	e Haven	Drive	Titu	1	le, FL	32780
ē,	item 27 i		20a. Method of Disposition	20b. F	Place of Dispo	sition (Na	me of	PILVE	Date	20c. Lo	ocation - City or	Town, State
E	Page nent o ent: If ury or		1	Hemoval from State			'1 Cem.	5/30	/2006	Arli	ngton,	Virginia
Baltimore,	parmit. Pages 1 Department of H Importent: If ite any injury or otl		21. Signature of Funeral Service Licer	1588	22	2. Name a	nd Address of F	Facility J	ohn M.	Tay1	or Fune	ral Home, Inc
_	20 = 20		Mith // Sha		1	47 D	uke of	Glouce	ster St			is, MD 21401
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deat one cause on each line.				ch as cardiac	or respiratory a	ırrest,		Approximate Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Alzhtima		Jem.	enfin.					401.
1	/Medical Examiner		f	Due to (or as a conseq	uence of):							
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conseq	uence of):							
	uted d ansit	i E	cause. Enter Underlying Cause (Disease or injury that initiated events									
ó	exac an an rial-tr	Exa	resulting in death) Last	Due to (or as a conseq	uence of):							
68760,	ficate be exacuted physician and s the burial-transit	edical Examiner	(_ d								
39	artifica ing ph e as t		IF FEMALE:	L								
Вох	eath cartiff attending I for use as	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	ldeath 3⊑		pregnancy				 Date of deli Month 	very Day Year
0	he de the a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnant at time of c 9□ Unknown	eath 5L	Other (s	респу)					
P.0	or Attending Physician: The law requires that the death cardifur death. Director: Atter this certificate has baen signed by the attending in by the funeral director, page 2 should be detached for use a		Part II. Other significent conditions	contributing to death but not res	ulting in the u	nderlying	cause given in f	Part I.	23e. Did	tobacco u	ise contribute to	the cause of death?
of Vital Records,	puires n sign ald be	d by							1 🗆	Yes 2	BNo 3□Pro	obably 4 Unknown
00	w require s baan si	Completed							24a. Was		24b. Were au	topsy findings available
Re	rhe lav te has age 2	mo							auto perfe 1 ☐ Yes	ormed?	death?	completion of cause of
ita	ician: Th certificate rector, pag	0	25. Was case referred to medical				26.1	Place of Dea	th (Check only			
f V	Physici this ce al direc	To B	examiner? 1 □ Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3□ D	OA Other: 4	☑ Nursing H	ome 5 Res	idence	6 □Other (Spec	city)
0	ding PI J. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury at Work?		28d. Describe	how injur	y occurred	
sio	tendi leath. Ior: A the fu	cati	2 Accident investigatio			М	1 🗆 Yes	2 🗆 No	006 1	(044		
Division	or At ifter d Diract in by	Certification;	4 Homicide determined			eet, facto	ry, office		City or To	wn, State	a Number or Hu)	ral Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: Atter this certificate his completely filled in by the funeral director, page		29a, Certifier 1 Certifying P	nysicien: To the best of my kno	wledne. deat	h occurre	at the time de	ite and place	and due to the	cause(e)	and manner as	stated.
	e Hos 24 h e Fun letely	edicai		niner: On the basis of examina and manner stated.								
	To th within To th	Me	29b. Signature and title of certifier			29	c. License num				te signed (Month	
			past ?.	m.			0359	250		Y	13/0	5 6
			30. Name and address of person who				-	/	0			~ ML 3/136
			/ 4		1 15-3		, (-,	· for	U. 1	くやシ	for a frame	~ ML 3/116
	Sta Registr		31. Date filed (Month, Day, Year)	Registrar's Signa	ature erun	A 0						

DHMH 17 Rev 1/2001

	1	For State Registrar	e of Maryland / Depa <i>Cer</i>	rtment of He tificate of D		Re	Z U U O g. No.	12595
Physicia /Medica	ñ	Decedent's Name (First, Middle, Last) Marian Golladay				2. Date of Death April	1 ^{Day} 200්රී	3. Time of Death 10:10 A
Examine		a. Facility Name (If not institution, give street an Andrus House	d number)	4b. City, Town, or 1 Bethesda	₹		4c. County of Death Montgome	
uneral irector		. Social Security Number 6. Sex 1 ☐ M 213	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 9,	Year) Cou	place (State or Fore intry) t Virginia
-f ahow	7	Jsual Residence of Decedent Oa. State 10b. County Montgomery	10c. City, Town or Loc Potomac	cation				10d. Inside City Lim 1 Yes 2 ☐ I
Sa or 28a	Director	10301 Gainsborough Ro	ad	10f. Zip Code	20854		g. Citizen of What Co. United Stat	-
	by Funeral	1 Never Married 2 Married 1 If Ye	ed Forces? If	Vas Decedent of His Yes, specify Cuban	panic Origin? (Spe , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh:	, etc.
than "natura to Medical E	Completed	15. Decedent's Education (Specify only highest grade comple	eted) 16a. Deced (Give I	ent's Usual Occupat kind of work done du OO NOT use retired) acher	tion uring most of works	ing	6b. Kind of Business/II Education	ndustry
ked other ic avant,	To Be Co	17. Father's Name (First, Middle, Last) Eustace Stevers			18. Mother's Name	(First, Middle, M	faiden Sumame)	
27 la mar r traumat	 	19a. Informant's Name/Relationship <i>(Type, Prin</i> Yvonne Lightsey/Daugh	•				City or Town, State, Zi	
Important: If Item 27 is marked out any injury or other traumatic aven once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal 1 ☑ Donation 5 ☐ Other (Specify)	from State 20b. Place of Disposers Geo. Wasi	natory of other place			Oc. Location - City or T Washington	
Importa any inju once.		21. Signature of Funeral Service Licenses	22	Name and Address			rtuary Ser , D.C. 2003	
sician ledical aminer		resulting in death)	a on each line. Alzheimens ue to (or as a consequence of):	er the mode of dying	, such as cardiac (n respiratory and	51,	Approximate Interval Between Onset and Death
physician and s the burial-transit	dicai Examiner	cause. Enter Underlying Cause (bloods or high) that initiated events c.	ue to (or as a consequence of):					
or use a	Physician/Medic	in the past 12 months?		Ectopic pregnancy Other (specify)	23		23d. Date of deli	very Day Year
gne bed	by	Part II. Other significant conditions contributin	g to death but not resulting in the ur	nderlying cause give	n in Part I.		acco use contribute to	the cause of death
sate has been si page 2 should I	Completed					24a. Was ar autopsy perform 1 \(\text{Yes} \) 2	prior to c ned? death?	topsy findings avai ompletion of cause 2 PNo
arctor: After this certificate hi by the funeral director, page	Certification; To Be	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury Work M 1 🗆 Y	at ? ′es 2 □ No	me 5 ☐ Reside 28d. Describe ho	nce 6 27 Other (<i>Spec</i> w injury occurred	Living
within 24 nouts after death To the Funaral Diractor: completely filled in by the		4 Homicide determined 286.	Place of Injury - At home, farm, stribullding, etc. (Specify) To the best of my knowledge, death			City or Town		
winin z4 nours are To the Funaral Dir completely filled in	Medical	(Check only 2 Medical Examiner: On	the basis of examination and/or ind manner stated.		inion, death occur	red at the time, da		to the cause(s)
		1 Cobet /	cause of death (Item 23a) (Type,	1		1	4/6/0 SREET 22202	
					7 /			

State of Maryland / Department of Health and Mental Hygiene

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1	1	ion	4.	9
- i	Eng	3	will	1

			1 - State Registrar			Cer	tificat	e of	Death	1		Reg. No		1 Earl 10 W	
	Physici /Medic		Decedent's Name (First, Middle, Las Jose E	nrique	G	arci	a	-			2. Date of De Month Apri	Day	y Year 2006	3. Time of D	eath M
The second second	Examir		4a. Facility Name (If not institution, give Shady Grove Ad)		Ro	ocki	r Location 7 i l l e	Э			County of Deal		
	Funeral Director		5. Social Security Number 6. Se 226-57-4103	x 7. A. XM 2□F	ge (In yrs. last	birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bir	7 ^h 1 ^y 9°4	4 Li	rthplace (State or Fountry) Ma, Peru	oreign
	e Maryland	ctor	10a. State 10b. County MD Montgo	mery	10c. City, T	own or Lo					-			10d. Inside City	
	th with the 23a or 28	ai Dire	10e. Street and Number 605 West Lynfi	eld Dri	ve		10f. Zip	Code 2085	50			10g. Cit	izen of What C	ountry?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other then "natural", or items 23a or 28a-1 show emportant: in item 27 is marked other then "natural", or items 23a or 28a-1 show emportant: in item 27 is marked other then a page.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☆ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 Tes 25 If Yes, Give Year or Dates:	?		Vas Deced Yes, spec		Specity:		city Yes or No Rican, etc.))-	14. Race - Am Black, Wh Specify:		
Baltimore, Maryland 21215-0036	i within 72 ho iene. r then "natur the Wedical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12	cation le completed) College (1-4or		(Give life. L	lent's Usua kind of wo DO NOT us 1rna	rk done se retired	ation during mos d)	st of workin	g		ind of Business vspape	Mindustry r/Radio	
yland 2	ould be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Last) Mario Garcia								(First, Middle ad Ga:		,		
e, Mar	1 and 2 sh Health and em 27 is m ther traum		19a. Informant's Name/Relationship (T) Merida Salazar 20a. Method of Disposition			60	5 We	st		ield		e Ro	or Town, State, OCKV11 ocation - City of	le,Md20	850
Itimor	nit. Pages artment of I ortant: if its injury or o		1 Burial 2 X Cremation 3 4 Donațion, 5 Other (30 ccify,		ceme	etery, cren esap	eake	ther place Cr	em.	4/08	/06	Be	ltsvil	le,Md	
Ba	Depoint of the control of the contro		23a. Part1. Enter the disease, or comp		d the death F	9	241	Col	umbi	a Bl	vd.Si	lve	SERVI r Spri	CE, P.A. ng, Md20	910
	Physician /Medical		shock, or heart lailure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each l a. <u>Cereb</u>	rovaso	cula				cardiac or	respiratory a	rrest,		Interval Between Onset and Dead days	
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Ather	oscle:	roti	с са	rdi	ovas	cula	r dis	ease	9	years	
68760,	certificate be executed rding physician and use as the burial-transit	ical Examiner	that initiated events resulting in death) Last	c	a consequen	ce of):									
O. Box	ires that the death certilica signed by the attending ph I be detached for use as th	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal dea		Ectopic pr Other (sp						23d. Date ol de Month	livery Day Yea	ır
rds, P.	The law requires that the death Ite has been signed by the atter bage 2, should be detached for u	ed by Pł	Part II. Dther significant conditions co		out not resultin	g in the ur	derlying c	ause giv	en in Part I	l		obacco u Yes 2		o the cause of deal	
Division of Vital Records,		Completed									24a. Was autor perio		prior to death?	utopsy findings ava completion of caus s 2 No	ulable se ol
Ϊŝ	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?					-11-		e of Death	(Check only o	one)			
5	hysi this c	ပ္	1 1 105 2 2 1 NO		ent 2 ER/	_			4 140				6 □Other (Spe	ecify)	
ision (of the land	Certification;	27. Manner of Death 1 Avatural 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Inju		o. Time of Injury	М		/ at k? Yes 2 □	No	8d. Describe				
2	pital or A	i Certif	4 Homicide determined		tc. (Specify)				W # 1500		City or To	wn, State) 	ural Route Number	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Medicai	20a Certifier (Check only one) 2 Medical Example 20b. Signature and title of certifier	ner: On the basis of and manner si	of examination	and/or inv	estigation	in my o	pinion, dea	ath occurre	d at the time,	date and	I place, and du	e to the cause(s)	
)	S = 1 = 2		Plucia J.	Hista	1 MI	>			9738	В			e signed (Mon		
			30. Name and address of person who c	listry	MD S	9901	Med	ica	l Ce	nter	Dr.R	ock	ville,	Md20850	
	Sta Registr		31. Date liled (Month, Day, Year) APR 0 7 20	06 32 Regist	rar's Signature	face	de								

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment ertificate			and M		giene Reg. No	.000	12597
	201		1. Decedent's Name (First, Middle, Las	t)						2. Date of De	ath Da	v Yea	3. Time of Death
	Physici /Medic		Grace Wilkins	son Ge ddi	ngs					April	4,	2006	8:15A M
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, T	Town, or	Location o	of Death		40	. County of De	eath
			28319 Kemptown Ro	oad		Dar	masc	us				Maryla	
	Funeral		Social Security Number 6. Security Number	7. Age	(In yrs. last birthday		1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da			Birthplace (State or Foreigr Country)
и.	Director		104-09-7730	JW 561	87 Yrs.					Sept.	20,	1918	Delaware
	pur M		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or I	ocation							10d. Inside City Limits
	sho	ō	N.Carolina Crave	an .	New	Bern							to Yes 2 No
	the Marylan 28a-f show notified at	ect	10e. Street and Number	-11	New	10f. Zip	Code				10g. Ci	tizen of What	Country?
	with a or	D	3802 Clearview Dr	civo			8562					U.S.A	
	ns 23e	Funeral Director	11. Marital Status	12. Was Decedent I	Ever in U.S. 13	Was Deced	ent of Hi	spanic Ori	gin? (Spe	cify Yes or No	0-	14. Race - A	merican Indian,
	or Items	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ N		If Yes, speci	rty Cubai	n, Mexican	n, Puerto i	Rican, etc.)	:	Black, W	hite, etc.
336	at', or	by	3 ⊠ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	No No	Specify:				Specify:	White
5-0036	72 hours after death with the Maryland "natural", or liems 23e or 28e-f show officel Exercities coast be notified at	Completed by	15. Decedent's Ed (Specify only highest gra		16a. Dec	edent's Usual e kind of worl	l Occupa	ation	t of worku	na	16b. K	(ind of Busine	ss/Industry
215	within 7 ene. then "n	ple	Elementary/Secondary (0-12)	College (1-4or 5	life.	DO NOT us	e retired,)	t or works	<i>'</i> 9			
21	filed withi Hygiene. other then	5	12			Homema						Own Hon	ne
pu	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, IT.e.Ms	Be (17. Father's Name (First, Middle, Last)					18. Mothe	er's Name	(First, Middle	, Maider	n Sumame)	
la	should be and Mental is marked o	2	William James	Wilkinsor				Mar		/irgini			
Maryland	iges 1 and 2 should be filed within 72 hours after death with the Maryla in of Health and Mental Hygiene. If Item 27 is marked other then "natural", or Items 23a or 28a-1 shoot of the 12 is marked other then "natural", or Items 23a or 28a-1 shoot or other traumatic event, Ira Madical Extractional particular at		19a. Informant's Name/Relationship (7	Type, Print)	19b. Mai	ling Address	(Street a	and Numbe	er or Rura	l Route Numb	er, City	or Town, State	e, Zip Code)
	and Balth n 27		Grace Fort - Daug	hter		9 Kemp		Road		amascu			A
ore	of He	1	20a. Method of Disposition 1 XBurial 2 Cremation 3	Removal from State	20b. Place of Disp cemetery, cr	ematory or ot	ne or ther place	θ)	U	ate	20c. L	ocation - City	or Town, State
Ĕ	Pag ment ant:		'4 □Denation 5 □ Other (Specify		Montgom								Maryland
Baltimore	permit. Pages 1 and 3 Department of Health Important: If Item 27 eny injury or other tr. once.		21. Signature of Funeral Service Licen	see) (. , , .) M	22. Name and Oleswo	Addres	s of Facilit	ty Lams	P.A.,	Fune	eral Ho	me
<u>m</u>	8 9 ≡ ₽ 9		23a. Part 1. Enter the disease, or com	Nella	ms $\frac{1}{2}$	6401 R	idge	Road	d, Da	mascus	, Ma	aryland	20872
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused one cause on each li	I the death. Do not e	nter the mode	e of dying	g, such as	cárdiac o	r respiratory a	arrest,		Approximate Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition	. Chroni	c obst	ructiv	ie	Dull	non	any a	dis	edse	uears
	/Medical		resulting in death)	Due to (or as	a consequence of):			/		/			l
М	Examiner		Sequentially list conditions.	b									
	70 ==	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):								
	ecute ind trans	am	that initiated events resulting in death) Last	C									
760,	ate be executed hysicien and the burial-transit		roduling in doubly cust	Due to (or as	a consequence of):								
œ	ate b	dical		d	83					. 307.50			
9 x	eath certificate attending phys for use as the	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregnancy							22d Date of	dolbrone
Вох	death cert e attendin ed for use	lan	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	☐Ectopic pre						23d. Date of Month	Day Year
o.	a a a	Sic	1 ☐ Yes 2 No 9 ☐ Unknown	9☐ Unknown	time or death 5	U Other (Spe	ecity)						
α.	requires that the de een signed by the a nould be detached t	Ph	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the	underlying ca	ause give	en in Part I	l.	23e. Did	tobacco	use contribute	e to the cause of death?
S,	sign d be	by	Congostive	heart	- tail	1/10				10	Yes 2	2 □ No 3 □	Probably 4 Dunknown
Ö	v requir been si should	Completed by			, -					24a. Was		24h Were	autoney findinge available
3ec	2 5	m								auto		prior	autopsy findings available to completion of cause of
=	ician: The l certificate ha rector, page									1 ☐ Yes	2 X N		'es 2⊠ No
Vital Records,	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			Othe	0.00		(Check only		2564 16	DAUGHTER
4	Phys this ral di	J.	1 Yes 2 No	1 🗀 inpatie			8c. Injury Work		de la companya della companya della companya de la companya della	me 5 🗆 Res 28d. Describe			pecity) HOMCE
E C	ding h. After funer	lö	1 ⊠Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) Injury	М		k? Yes 2 🗌	No		·		
Division of	Attending r death. ector: After by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not b		ury - At home, farm,	street, factory	, office	_					Rural Route Number,
<u></u>	after Dire	erti	4 Homicide determined	building, et	c. (Specify)					City or To	wn, Stat	te)	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	C	29a. Certifier 1 Certifying Ph	ysician: To the best	of my knowledge, de	ath occurred	at the tin	ne, date ar	nd place,	and due to the	cause(s	s) and manner	as stated.
	24 h Fur	edical	(Check only 2 Madical Exar	niner: On the basis of and manner st	f examination and/or	investigation,	, in my o	pinion, dea	ath occurr	ed at the time,	, date an	nd place, and	due to the cause(s)
	o thi	Me	29b. Signature and title of certifier	. ,7	111	M. 9 290	License	e number	^		29d. Da	ate signed (M	onth, Day, Year)
	->-0		Protecia	Touska	May,	1160	1)3	519	16		AX	oril E	, 2006
1			39 Name and address of person who	completed cause of o	leath (Item 2 a) (Typ	e, Print) /	• 1 /	10	1	0 15	1	0 1	·1/
V)		Patricia Tom.	sko Nau	1, 1/1/9	Rocki	11//8	P	ike,	B-100	9 K	Kocki	i/e, MD 2085
	St	ate	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature						,		
	Peniet	rar	APR 0 7	YOUR MAN	- 4								

ORIGINAL

DHMH 17 Rev 1/2001

			1- For Amend Items 24a,25,26,27,29a per Dr	epartment of Health and M	Mental Hygi		2598
		п	Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici		Garry Albert Gutberlet		April 3,	2006 Year	3:15 P. M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	3.13 1.
		•	114 Woody Brown Road	Rising Sun		Cecil	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	day) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Jan. 7,		lace (State or Foreign try) Ja
	pur A		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of	or Location			Od Incide City timin
	sho	5					0d. Inside City Limits 1 ☐ Yes 2 No
	he №	Director	MD Cecil Rising				
	with t		10e. Street and Number	10f. Zip Code		g. Citizen of What Coun	itry?
	s 23a	rai	114 Woody Brown Road	21911		U.S.A.	
2-003p	d within 72 hours after death with the Maryland join. It then neturel, or tems 23a or 28e-1 show the Medical Examinational be notified at	by Funeral	3 ☐ Widowed 4 ☐ Divorced	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes	ecity Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whit	etc.
2	72 ho	Completed	15. Decedent's Education 16a. D (Specify only highest grade completed) (6	ecedent's Usual Occupation Give kind of work done during most of work	10	5b. Kind of Business/Inc	dustry
V	thin	npie	Elementary/Secondary (0-12) College (1-4or 5+)	ife. DO NOT use retired)			
7	T1 C0 10 10 10 10 10 10 10 10 10 10 10 10 10	Col	12 0 Re	pairman	G	eneral Moto	ors
yland	should be filed and Mental Hygis marked othe amatic event,	To Be	17. Father's Name (First, Middle, Last) Albert Gutberlet	Phylli	e (First, Middle, Miss Diewold	l	
, mar	nd 2 salth ar 27 is		Carol Gutberlet (Wife) 114	Mailing Address (Street and Number or Run Woody Brown Road	Rising S		
Бапптоге	t. Pages 1 a rtment of Hez rtent: If Item rjury or othe			crematory or other place)		oc. Location - City or To lest Cheste	
Dall	permit. Pag Department Importent: eny Injury o		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Tarring-Cargo Fur Aberdeen, Maryland	geral Hom	e. P.A. 3399	
П	烂		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.			t,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) August 10 (or as a consequence of the condition of the condi	n Junen			Onset and Death
	Examiner		CHIDNARY	moun nisemo			
	outed id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or Injury that initiated events	Asulan Disepte			
/60,	ate be executed hysician and the burial-transit	Icai Exa		EMPOSURIC GASTROS	tony Th	he popularine	11
ĝ	tifical g ph) as th	ed .					
O. BOX	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 1 □ Yes 2 □ No 9 □ Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delive Month	ry Day Year
cords, F.	n requires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the Community of the Commun	he underlying cause given in Part I.	_	cco use contribute to th	e cause of death?
	w rec	Completed	Whire Wales the proposion land		24a. Was an	24h Were autor	osy findings available
E E	i icien : The lav certificate has rector, page 2	m.	Class Carlotte Market Control		autonsy	prior to cor	npletion of cause of
	n: TI ficate rr, pa		office has symboline		performe 1 Tes 2	No 1 ☐ Yes	2 X No
VII	sicie certi recto	Be	25. Was case referred to metrical examiner?	Other	h (Check only one)		
on or	Attending Physicien: r death. ector: After this certific. by the funeral director,	tion: To	1 Yes 2 No Nospital. Inpatient 2 ER/Outp. 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day Year) 28b. Tim	ne of 28c. Injury at	me X Residen 28d. Describe how	ce 6 Other (Specify injury occurred)
DIVISION	or Attendionation after death. Director: A in by the further in the present the further in the f	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	s, street, factory, office	28f. Location (Stre City or Town,	et a <i>nd Numb</i> er or Rura State)	Route Number,
	To the Hospitel or Atteni within 24 hours after deatl To the Funerel Director: completely filled in by the	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, of the basis of examination and/of and manner stated.	death occurred at the time, date and place, or investigation, in my opinion, death occurr	and due to the cau red at the time, dat	se(s) and manner as st a and place, and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	290	. Date signed (Month, I	Day, Year)
			+ Hi SUP Sim	D46412		4/5/06	
_	5		30 Name and address of person who completed cause of death (Item 23a) (Ty	VPOPrint) (V) AV	H06 A	10 2007	8
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 2 0 2006	W		,	

		For State Registrar	State of Maryland		rtment of H		-	giene Reg. No.	006	12599
		Decedent's Name (First, Middle, La.	st)				2. Date of De	ath	Vaar	3. Time of Death
Phys		WILLIE	CAR	VETT.			April	2,2	006	2:13A M
	dica! niner	4a. Facility Name (If not institution, giv		*****	4b. City, Town, or	Location of Death		4c. 0	County of Dea	th
		Laurel Regiona	l Hospital		Laurel			P:		George
Funer	al	5 Social Security Number 6.5	ex 7. Age (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	y, Year)		thplace (State or Foreign ountry)
Directo	or	215-20-4113	93	Yrs.			Feb.1	,191	3 V.	irginia
and w	S	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loc	ation					10d. Inside City Limits
Mary	Ì	MD Prince	George 1	Laure	1					1 ☐XYes 2 ☐ No
the 128a	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Co	ountry?
3 with		346 Dameron S	outh		2072	4		U	.S.A.	
death ma 2	9	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp	pecify Yes or No)- 1	4. Race - Ami Black, Whi	
after or ite	ů		1 Yes 2 No		Yes 2XNo	Specify:	o 1110a11, 010.7		Specify: B	
ours ours	1	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:							
72 h	petelomo	15. Decedent's E (Specify only highest gro		16a. Deced (Give)	ent's Usual Occupa kind of work done o OO NOT use retired	ation during most of wor	king	16b. Kin	d of Business	s/industry
Mithin New Year	2	Elementary/Secondary (0-12)	College (1-4or 5+)		orer	/		Co	nstru	ction
iled with the th	5	17. Father's Name (First, Middle, Last)			18. Mother's Nam	ne (First, Middle	, Maiden S	Sumame)	
Vizing build be fill Mental H arked oth	a	_				Mary V	West			
Mark mark	F	19a. Informant's Name/Relationship		19b. Mailin	g Address (Street a			er, City or	Town, State,	Zip Code)
Mar nd 2 sh lith and 27 ts n rtraun		Virgie Garnett	- Daughter	346	Dameron	South	Laure	L, M	D 207	24
DESITIMOTE, INISTYISTING Z.I.Z. 13-0030 permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "naturel", or itema 23s or 28s-f. show any injury or other traumatic event, Ite Musical Examinar must be notified at	2	20a. Method of Disposition	20b. Pla	ce of Dispo	sition (Name of natory or other plac	e)	Date	20c. Loc	cation - City or	r Town, State
Baltimore, Dermit. Pages 1 al Department of Hez Important: If Itam any injury or othe		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	JHemovai from State		Cem		/2006	La	urel,	MD
mit. partit porta	8	21. Signature of Funeral Service Lice	nse							Home, PA
n 88 E 5	8	Coops +	Solvely						ville	, MD20850
		23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused the death. one cause on each line.	Do not ente	er the mode of dyin	g, such as cardiac	or respiratory a	ırrest,		Approximate Interval Between Onset and Death
Physicia	an	Immediate Cause (Final disease or condition	ACUTE MY	YOCAF	RDIAL IN	FARCTI	NC			Oriset and Death
/Medic Examin		resulting in death)	Due to (or as a conseque							
CXAIIIII		Sequentially list conditions,	b. CORONAR!		ERY DIS	EASE				
ed sit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ince or).						
6U, be executed ician and burial-transit		that initiated events resulting in death) Last	c	nce of):						
B / 6U, sate be executed shysician and the burial-transit			d							
OX 68/ certificate ding phys			u							
BOX 68 leath certifica attending ph		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnand		Ectopic pregnancy			2	3d. Date of de	,
. 0 0 9		in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of dea		Other (specify)				Month	Day Year
at the de di by the setached		9 Unknown					an Did			to the cause of death?
<u> </u>		Parti. Other significant conditions	contributing to death but not result	ling in the ui	nderlying cause giv	en in Part I.	1			Probably 4 X Unknown
ecords, law requires that see a signer as been signer to should be a signer to see a signer to									1	
law law las b		2					24a. Was		24b. Were a prior to death?	autopsy findings available completion of cause of
	2						1 ☐ Yes		1 ☐ Ye	s 2 📉 o
VITS ician icertifi		25. Was case referred to medical examiner?	Hospital:		• all pook Oth	er:				
Of Phys r this	[] P	1 ☐ Yes 2 X No 27. Manner of Death	1 Inpatient 2	28b. Time of	3 DOA	4 Li Nui siriy i	lome 5 Res 28d. Describe			өсігу)
On On ding Figure 1. After		1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		k? Yes 2⊡No				
Division of VIta to Attending Physician: after death. Director: Atter this certific, in by the funeral director.		3 Suicide 6 Could not determined	286. Place of injury - Action	ne, farm, str	eet, factory, office			(Street and		Rural Route Number,
DIV salor A safter al Direct		27. Manner of Death 1	building, etc. (Specify)				Oily or 1			y.
To the Hospital or within 24 hours at To the Funeral D	and display	29a. Certifier 1 XCertifying P	hysicien: To the best of my know miner: On the basis of examination and manner stated.	rledge, deati on and/or in	n occurred at the tir vestigation, in my o	ne, date and place pinion, death occu	e, and due to the urred at the time	cause(s) , date and	and manner a place, and du	as stated. ue to the cause(s)
o the		29b. Signature and title of certifier	N 1		29c. Licens	e number		29d. Date	e signed (Mor	nth, Day, Year)
		1 William	H War	ev, M) D13	3916		Ap:	ril,	2, 2006
U		30. Name and address of person who								
			Warren, MD 32			orge St	Laure	L , M	D 207	0.7
Rec	Stat gistra		32 Registrar's Signatu	ILE ALL	and I					

DHMH 17 Rev 1/2001

6:35PM

1 Yes 2 No

Approximate Interval

Between Onset and

Death

Physician/Medical Examiner Certification: To Be Completed

Division of Vital Records, P.O. Box 68760,

UNPENDED	AMENDED					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pre 1 Live birth 4 Pregnant at time of c 9 Unknown	2 Fetal dea			3d. Date of delivery Month Day	Year
Part II. Other significant conditions of	ontributing to death but not	resulting in the underlyi	ng cause given in Part I.	1 Yes 2 24a. Was an autopsy performed?		4 Unknown
25. Was case referred to medical examiner? 1 Yes 2 No	spital: 1 Inpatient 2 _	ER/Outpatient 3	26 Place of Death (Chec	, ,	dence 6 Other	
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month Day, Year) Apr 2, 2006	28b. Time of Injury 3:45:00 AM	28c. Injury at Work? 1 Yes 2 ✓ No	28d. Describe how in Subject stabbed		
3 Suicide 6 Could not be 4 ✓ Homicide determined	28e. Place of Injury - At I		ry, office building, etc.	or Town, State)	and Number or Rural Ret, Pocomoke City	
29a Certifier 1 Certifying Physician	: To the best of my knowle	dge, death occurred at t	he time, date and place, ar	nd due to the cause(s) a	and manner as started	

and manner as started 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 3, 2006 30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registrar

Medical

ORIGINAL

			For State Registrar		State of	Marylan		artment rtificate			and M	-	giene Reg. No .	006	12601
	p)		1. Decedent's Name (Fit		-							2. Date of De Month		Year	3. Time of Death
	Physici /Medio		THELMA I									APRIL	16	2006	12:15 AM
	Examin	er	4a. Facility Name (If not	institution, give	street and nur	AC 7 -	_	4b. City, I	Fown, or	Location of	of Death		4c. C	County of Death	À
	Funeral		5. Social Security Numb			7. Age (In yrs.	last birthday)	If Under 1		If Under		8. Date of Bir	th Vacel	9. Birth	place (State or Foreign
	Director		218-28-0479		□ M 2□ X F	75	Yrs.	Months	Days	Hours	Min.	8. Date of Bir	1930	Mar	yland
	land		Usual Residence of Dec 10a. State 10b	edent c. County		10c. City	y, Town or Lo	ocation		-					10d. Inside City Limits
	Mary B-f sh	tor	MD 1	Harford			Aberde	een							1 ☐ Yes 2 X No
	death with the Maryland ms 23a or 28e-f show	Director	10e. Street and Number					10f. Zip			-		_	en of What Cou	intry?
	eath v		136 N. Po	st koad	12. Was Dece	dent Ever in U.	S. 13.		.001	ispanic Ori	ain? (Spe	ecify Yes or No	USA - 1	4. Race - Amer	ican Indian.
036	e = 3	by Funeral	1 Never Married		Armed For 1 Tyes If Yes, Give Year or Da	ces? 2 [<u>X</u> No e		If Yes, speci 1 ☐ Yes 2	fy Cuba	Specify:	n, Puerto	Rican, etc.)		Black, White Specify: Wh	, etc.
5.0-5	72 hours "naturel",	eted	15. (Specify o	Decedent's Edi	ucation de completed)		(Give	dent's Usual kind of work	k done d	durina mos	t of worki	ng	16b. Kin	d of Business/li	ndustry
KIN 21215	within ene. then "	Completed	Elementary/Secondar	y (0-12)	College (1	-4or 5+)		ng Mac			rato	r	Manı	ıfactur	ing
Hop KiNS Maryland 21215-0036	be filed tat Hygi d other event, I	To Be Co	17. Father's Name (First John Spar							18. Mothe Ma.	er's Name	<i>(First, Middle</i> ochran	. Maiden S	Sumame)	
a a	ges 1 and 2 should t of Health and Men If item 27 is marke or other treumatic.	A STATE OF	19a. Informant's Name/ Glenda Ram									deen, M		Town, State, Zi 1001	p Code)
TEIMA Baltimore, I	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tre		20a. Method of Disposit 1 X Burial 2 ☐ Cr `4 ☐ Donation 5 ☐	emation 3 🗆			lace of Dispo emetery, cres Air N	matory or oth	her plac	ens 4		2006		ation - City or T Air, MD	own, State
The Balti	permit. Departn Importe any inju		21. Signature of Funera	Service Licens	See Jan	el. Z		2. Name and arkins				e, Inc.	, Del	lta, PA	17314
	Physician		23a F. m.1. In he di hock, or heart fai Immediate Cause (Fina disease or condition resulting in death)		a	ever	e 1	er the mode	of dying	g, such as	cardiac o	or respiratory a	rrest,)	Approximate Interval Between Onset and Death
	/Medical Examiner			ons,	b	or as a consequence or a consequence or a consequen									
Š,	be executed ician and burial-transit	Examiner	Sequentially list condition if any, leading to immediate. Enter Underlyin Cause (Disease or injurthat initiated events resulting in death) Last	g y	c	or as a consequence									
8760.	ate ohys	dical		l	d										
.O. Box 6	eath cert attendin for use	Physician/Me	IF FEMALE: 23b. Was decedent pre in the past 12 mon 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	gnant iths?		irth 2 ☐ Feta ant at time of d	death 3	⊒Ectopic pre ☑ Other <i>(spe</i>					23	3d. Date of deliv Month	rery Day Year
ds. P	uires that signed b	ρ	Part II. Other significan	t conditions co	ontributing to de	ath but not res	ulting in the u	nderlying ca	ause give	en in Part I.			obacco us Yes 2		the cause of death?
Division of Vital Records, P.O.	ne law requires been ge 2 should	Completed	Clos	tridi	vim I), ff.	ale	(%)	tis	`		24a. Was auto perio		24b. Were aut prior to co death?	opsy findings available ompletion of cause of
ta	icien: The l certificate ha ector, page	0	25. Was case referred t	omedical					-	26. Place	of Death	1 Yes		1 🗌 Yes	2 € No
į. Ž	Physicien: this certific al director,	To B	examiner?	-	Hospital: 1 ☐ II	npatient 2	ER/Outpatier	nt 3 🗆 DO/	A Othe	20 /				□Other (Spec	ity)
ion o	ttending Pt death. ctor: After th y the funeral		27. Manner of Death 1 ☑ Natural 5 2 ☐ Accident	Pending investigation		of Injury h, Day Year)	28b. Time o Injury	f 28	Bc. Injury Work 1 🔲 `	/at <br Yes 2 □		28d. Describe	how injury	occurred	
Divis	el or Atte s after de il Directo	Certification:	3 ☐ Suicide 6 4 ☐ Homicide	Could not be determined	280. Place	of Injury - At hong, etc. (Specif	ome, farm, str	reet, factory,	, office			28f. Location (City or To		Number or Rui	al Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: All completely filled in by the fur	Medical C	29a. Certifier 12 (Check only one)	Certifying Phy Medical Exam	ysician: To the niner: On the ba and mann	asis of examina	wledge, deat tion and/or in	h occurred a vestigation,	at the tim in my or	ne, date an pinion, dea	d place, a	and due to the ed at the time,	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title	of certifier	A	W)		29c.	License	number			29d. Date	signed (Month	Day, Year)
	(1		30. Name and address	of person who	completed caus	and death (Item	23a) (Type,	Print)	7	117.	1	3 7	Apri	117	,2006
	7		Mame	M.	476	Pi I	77	A	la	W.	TR	eb	Xb	evdec	7
:	Sta Regist		31. Date filed (Month, D		006	egistrar's Signa	ture A	and a	,	/	1 5	1 · V ·	- 10	- 1	

			for State	State	of Marylan	d / Depa	ertment of H	lealth ar	nd Mental Hy	giepe	006	12602
			Registrar 1. Decedent's Name (First, Middle	I net)		Cer	unicale or i	Dealii	2. Date of De	Reg. No).	3. Time of Death
	Physicia	an							Month	Da		
	/Medic		Ernest Albrecht 4a. Facility Name (If not institution,				4b. City, Town, or	r Location of	Apri		. 2006 . County of De	
	Examin	er	Citizens Care &	-			Freder		Oballi		ederick	
	- 3 >			6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24		rth		rthplace (State or Foreign Country)
	Funeral Director		265-52-4170	1 🔀 M 2 🗆 F	74	Yrs.	Months Days	Hours	Min. (Month, Da	ау, Үөа <i>г)</i> 23	1931 G	Country) ermany
	p.		Usual Residence of Decedent									
	how	L	10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	Ba-f e	cto	Maryland Freder	rick		Freder						1 XYes 2 No
	or 2	Dire	10e. Street and Number				10f. Zip Code	0.0			tizen of What (•
	s 23s	srai	1900 Rosemont A		and and Francis III	6 10 1	2170		-2 (C===#. V== == N		nited S	
	ter de	Funeral Director	11. Marital Status 1 □ Never Married 2√ Marri	Armed F		/.	Yes, specify Cuba	n, Mexican,	n? (Specify Yes or No Puerto Rican, etc.)	J-	Black, Wh	
	ors at	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or I	2 No 1954 ive Dates: 195		∏Yes 2√2 No	Specify:			Specify:	White
5	2 hor	Completed	15. Decedent			16a. Deced	lent's Usual Occup	ation	of wordship o	16b. K	and of Busines	s/Industry
7	B. B. Med	pie	(Specify only highes Elementary/Secondary (0-12)	T	(1-4or 5+)	life. L	kind of work done of OO NOT use retired	duning most c	si working			
7	gien gien er th	Con			5+	Ed	ucator					Government
<u>a</u>	al Hy al Hy al oth	Be (17. Father's Name (First, Middle, I						s Name (First, Middle			
y a	Ment Ment arke	2	Fritz Honigmann						lotte Depa			
Mar	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. To Health and Mental Hygiene. To Health and Mental Hygiene. To ther treumatic event, the Madical Examinar must be notified at or other treumatic event.		19a. Informant's Name/Relationsh Elba Honigmann						or Rural Route Numb e, N. Beth			
บ์	permit. Pages 1 an Department of Heal Important: If Item 2 eny injury or other ance.		20a. Method of Disposition		20b. P	Place of Dispo	sition (Name of natory or other place	(0)	Date	20c. L	ocation - City o	r Town, State
Dallilli	Page lent o nt: If iry or		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sc		I State	_	n Cremato	A	pril 8, 2006	Fre	derick.	Maryland
<u>=</u>	permit. Departminity imports any inju		21. Signature of Fundamental	JCBNSBB	1	P.22	. Name and Addres	ss of Facility	1 Services			
٥	8858		1//	1		- 95	01 Catoci	tin Mt:	n. Hwy. Fr	eder	cick, M	D 21701
			23a. Parti. Enter the disease, or shock, or eart failure. List	on one cause on	caused the deatl	h. Do not ente	er the mode of dyin	g, such as ca	ardiac or respiratory a	arrest,		Approximate Interval Between
į [Physician		Immediate Cause (Final disease or condition	//					c Pleural E		ions	Onset and Death
	/Medical		resulting in death)		(or as a conseq							
	Examiner	_	Sequentially list conditions,		tension							yrs.
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		orasa consequary Arte		0.000					777°C
	licate be executed physician and s the burial-transit	xan	that initiated events resulting in death) Last		(oras a conseq		ease					yrs.
0/00,	siciar burià	dical E		Diahe	tes Mell	itue						vrs.
00	ficate p physics the	edic		ODIADC.								yrs.
Š	nding use a	M/M	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		1 -				23d. Date of d	alivery
٥	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Preg	birth 2 ☐ Feta nant at time of d		Ectopic pregnancy Other (specify)				Month	Day Year
5	by th	hys	9 Unknown	9□ Unki	nown							
'n	gned god	by F	Part II. Other significant condition				, ,			tobacco		to the cause of death?
5	equir en si ould	ted	Hypothyroidism,	Hyperlip	idemia,	Periph	eral Vasc	ular Di	<u>is-</u> 10	Yes 2	<u>M</u> No 3□I	Probably 4 Unknown
records,		Completed	ease, Seizure,	Gastroesc	phagal :	Reflux	, Benign	Prosta	ate 24a. Was		prior to	autopsy findings available completion of cause of
_	sician: The law s certificate has b lirector, pege 2 si	Con	Hypertrophy, An	kiety, De	pression	n			perf	ormed? 2 <u>k</u> ZNo	death?	s 2 No
V [2	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?				1.00		of Death (Check only	one)		
_	2 20	To	1 ☐ Yes 2 No			ER/Outpatien		4)XXINUIS	sing Home 5 Res			ecify)
	Jing I	ion	27. Manner of Death 1 Natural 5 □ Pending		of Injury nth, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2.∐No	28d. Describe	now inju	ry occurred	
UNISION	Attending in death. ector: Alter by the funer	lical	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n	ot be 300 Blac	e of Injury - At ho	ome farm str	eet, factory, office			(Street a	nd Number or I	Rural Route Number,
<u> </u>	after Dire	Certification:	4 ☐ Homicide determi	build	ding, etc. (Specif	y)	out, ractory, critico		City or To			
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: Alter th completely filled in by the funeral		29a. Certifier TS Certifyin	g Physician: To th	e best of my kno	wledge, death	occurred at the tin	ne, date and	place, and due to the	cause(s) and manner	as stated.
	the H in 24 in Et	ledical	(Check only 2 Medical I		basis of examina nner stated.	tion and/or inv			occurred at the time	, date an	d place, and di	ue to the cause(s)
	To t ro t	×	29b. Signature and the of certifier	I.	:11	. и.	29c. Licens	e number		29d. Da	ate signed (Moi	nth, Day, Year)
	W.		· well	1 /Ce	u	111	D 5	4749		Apı	cil 7,	2006
<	24/1/10		30. Name and address of person	•	1/							
-).		J. Allen Reilly		801 To 11		Ave., S	te. D-	l, Frederi	ick,	MD 217	01
	Sta Registr		31. Date filed (Month Day, Year)		agistrar's Signa		and the					

			1 - For State Registrar	State of Maryland / Depa	artment of H rtificate of I			22e) 0 6	12603				
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Virgil Howard, Ju	r.			2. Date of Death Month April 4,	Day Year 2006	3. Time of Death 6:30 AM				
	Examin		4a. Facility Name (If not institution, give s Sligo Creek Nursi	ng & Rehab.	Takoma			ry					
	Funeral Director		5. Social Security Number 417-28-2744 Usual Residence of Decedent	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9. Birth	place (State or Foreign intry) abama				
	he Maryland 8a-f show	Director	MD 10b. County Prince Go	eorges Hyattsvi	11e				10d. Inside City Limits 1 Yes 2 No				
	N with th	ai Dire	10e. Street and Number 6637 23rd Place		10f. Zip Code 20782			nited Stat					
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "natural", or items 23a or 28a-f show avent, the Medical Examinar natal be rutilied at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	1 □Yes 2X No	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto Specify:		14. Race - Amer Black, White	ican Indian,				
	within 72 horens one. then "natural he Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12) 12	College (1-4or 5+) (Give life.	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of worki	ing 16	Private					
nd 2	be filed tal Hygid d other	Be Co	17. Father's Name (First, Middle, Last)		uscaping		e (First, Middle, Ma						
aryla	should be nd Menta marked umatic so	To	Virgil Howard, Sr. 19a. Informant's Name/Relationship (Typ.	^{Do, Print)} (daughter) ^{196. Maili}	ng Address (Street	Pinkey (City or Town, State, Zi	ip Code)				
Š 6	fealth a mm 27 is		Jacquelyn Howard I	McKissic 740	4 8th St.	N.W., Wa	shington	, D.C. 20	0012				
Baltimore,	permit. Pages 1 and 2 should be Depertment of Health and Menta Important: If item 27 is marked eny injury of other traumatic as once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	Chesapea	ke Cremat	ory 4/1	1/06 B	eltsville,	MD				
Ball	permit Depert Import eny in		21. Signature of Funeral Service License Lineline J			^{ss of Facility} McGu gia Ave. N		ral Servio h. D.C. 2	e 20012				
September 1	Physician		Immediate Cause (Final disease or condition	cations that caused the death. Do not ent te cause on each line. Coronary Arte			or respiratory arrest	t,	Approximate Interval Between Onset and Death				
	/Medical Examiner		resulting in death)	Due to (or as a consequence of): Cerebrovascu	lar Acci	ldent							
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Oisease or injury that initiated events	Due to (or as a consequence of): Systemic Hype	ertensio	on							
68760,	ifficate be executed g physicien and as the burial-transit	edicai Exa	resulting in death) Last	Due to (or as a consequence of):									
O. Box	law requires that the death certific as been signed by the attending pl 2 should be detached for use as i	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)	,		23d. Date of delive Month	very Day Year				
rds, P.	v requires that been signed b should be deta	by	Part II. Other significant conditions con	tributing to death but not resulting in the u	inderlying cause give	en in Part I.		cco use contribute to	the cause of death?				
al Records,	The ate h	Completed					24a. Was an autopsy performe	d? death?	opsy findings available ompletion of cause of				
Vital	yeician: S s certifical director, p	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 Inpatient 2 ER/Outpatier	nt 3□ DOA Oth		Check only one	e 6 □Other (See	·6.1				
Division of	To the Mospital or Attending Physician: within 24 hours effer death. To the Funerel Director: After this certifical completely filled in by the funeral director.		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	f 28c. Injun Work			ne 5 Residence 6 Other (Specify) 28d. Describe how injury occurred					
DIVIS	ital or Attend rs efter death el Director: ,	Certification:	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Specify)	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital within 24 hours of To the Funeral completely filled	Medical	29a Certifier Certifin Physical Check only 2 Medical Examination	ner: On the basis of examination and/or in and manner stated.	vestigation, in my o	na data and place i pinion, death occurr	and due to the cauc ed at the time, date	e and place, and due	change. to the cause(s)				
	To th withir To th	Me	29b. Signature and title of certifier	n Ru -	29c. License			. Date signed (Month,					
,	5		30. Name and address of person who co	mpleted cause of death (Item 23a) (Type,				ril 5, 2	006				
			Steven Tee, M.D 31. Date filed (Month, Day, Year)	3415 Hamilton	n St. H	Iyattsvi	lle, MD	20782					
- 3	Sta Registr		APR 0 6 200		all!								

			1 - For State Registrar		State of M	arylar			nt of H te of L		ind Me	_	giene Reg. No.	JU0	The second secon	2604
	Physici /Medic		Decedent's Name (First, Mic KUO-HSIUNG HO	ldle, Last)						l a	2. Date of De Month APRIL 3,	ath Day		'ear)06	3. Time of Death 2:25 A M
	Examin Funeral Director		4a. Facility Name (If not instituted CASEY HOUSE 5. Social Security Number 095-32-4586	6. Se			last birthday) Yrs.	I	y, Town, or ROCKVIL er 1 Year Days			3. Date of Bir (Month, Da 1/15/19	th ly, Year)	MONT(OMER	lace (State or Foreign try)
	D D	٥٢	Usual Residence of Decedent 10a. State 10b. Cour	oty COMERY		10c. Ci	ty, Town or Lo					1/15/19	21			AN Od. Inside City Limits 1 □ Yes 2 X No
	be filed within 72 hours after death with the Maryland tal Hyglene d other then "natural", or iteme 23a or 28e-f ehow event, tra Madical Examinar must be notified at	erai Director	10e. Street and Number 12100 DAMSON DRI					10f. Z	10f. Zip Code 20878				10g. Citizen of What Country? USA			itry?
0036	hours after d ural', or iterr il Examinari	d by Funeral	11. Marital Status 1 Never Married 2 M M 3 Widowed 4 Divorce	ed	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	?		1 🗌 Yes	2[X No	Specity:	, Puerto R	ify Yes or No ican, etc.)		Black, Specify:	White,	etc. AN
21215-0036	filed within 72 l Hygiene. ther then "nat int, tre Medici	Completed	15. Deced (Specify only hig Elementary/Secondary (0-12	hest grad	ucation de completed) College (1-4or 5+) 5+ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) COLLEGE PROFESSOR						7	16b. Kind of Business/Industry EDUCATION			dustry	
Baltimore, Maryland 21	2 should be filed vor and Mental Hygie Is marked other treumatic event, In	0	17. Father's Name (First, Midd DAR HO 19a. Informant's Name/Relation		vne Printl		10h Maili	ng Addro	os /Street a	S	HANG-G	(First, Middle, GAY CHEN Route Number			ete 7ie	Code
	1 and Heelth em 27		AI-CHU HO - WIFE 20a. Method of Disposition 1 ☑ Burial 2 ☐ Crematio	,		20b.		DAMS	ON DRI	VE; NO		TOMAC M	D 208			
Baltim	permit. Pages Depertment of I Important: If It eny injury or o		4 Donation 5 Other 21. Signature of Funeral Servi	(Specify)			ADOWRIDG 22 1	2. Name	and Addres	s of Facility	HINE	006 S-RINAL SILVER	DI FU	IDGE, NERAL NG MD	HOME	<i>'</i>
Pnysiciar /Medica Examiner	the the	edicai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): RENAL FAILURE Due to (or as a consequence of):									Approximate Interval Between Onset and Death				
O. Box	The lew requires that the death certific the has been signed by the ettending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Feta	al death 3	⊒Ectopic] Other (:	pregnancy specify)					23d. Date (Month		ory Day Year
Д.	w requires that been signed b should be deta	þ	Part ii. Other significant continuous continuous to death but not resulting in the underlying cause given in Part i.											ably 4 []Unknown		
ital Rec		e Completed	25. Was case referred to medi	cal						26. Place	of Death	1 Yes	osy rmad? 2 \(\tilde{\Delta}\) No	prid	or to con	psy findings available inpletion of cause of 2 No
Division of Vital Records,	ding Phys h. After this funeral di	ation: To B		ding stigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Desc						e 5□Resi	k only one ☐ Residence 6 ☐ Other (Specify) HOSPICE scribe how injury occurred				
DIVIS	- 2	al Certification;	4 Homicide dete	Id not be imined ving Phy	building, e	e of Injury - At home, farm, street, factory, office 28f. Locati City of e best of my knowledge, death occurred at the time, date and place, and due to					City or Tou	cation (Street and Number or Rural Route Number, y or Town, State)				
	To the Hospital of within 24 hours of To the Funeral D completely filled in	Medical	(Check only 2 Medic one) 2 Medic 29b. Signature and title of cert	al Exam	ner: On the basis of and manner si	of examin	ation and/or in	vestigatio	9c. License	number	h occurred	d at the time,	date and 29d. Dat	place, and	d due to	o the cause(s) Day, Year)
			30. Name and address of pers JOSEPH KAPLAN M	.D.	6001 M	UNCAS:	TER MILL	ROAD		/ILLE N	D 208	55				
	Sta Registi		31. Date filed (Month, Day, Ye APR 0		06 37 Regist	rar's Sign	atyre A	We .	•							

			For State	State of Ma	aryland /	Departme Certifica				E.m	006	12605
			Registrar 1. Decedent's Name (First, Middle, Last	st)	. ;	Cortino	210 07 1	Death	2. Date of De			3. Time of Death
	Physicia /Medic		100	arles	Hage				Month	3		2020 M
	Examin	er	4a. Facility Name (If not institution, give	street and number)	ital	4b. C	ity, Town, or	Location of Deat	h	4c.	County of Death	
	Funeral		5. Social Security Number 6. S		e (In yrs. last b	pirthday) If Un Monti	der 1 Year hs Days	If Under 24 Hrs Hours Min.		th V Year)	HILEGA 9. Birth	place (State or Foreign
	Director		213-22-3796 Usual Residence of Decedent	M 2□F	79	Yrs.	Days	Hours Will.	20-Aug-		Mary	
	yland		10a. State 10b. County		10c. City, To	wn or Location						10d. Inside City Limits
	Be-f e	Director	Maryland Allega	ny	Frostbu	rg						1 Yes 2 □ No
	with the or 2		10e. Street and Number 128 Pine	Street			Zip Code			-	zen of What Cou	ntry?
	72 hours after death with the Maryland natural, or Iteme 23a or 28e-f ehow disal Examinar must be notified at	by Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.		1532- ecedent of H	ispanic Origin? (S In, Mexican, Puer	Specify Yes or No	U.S.	14. Race - Ameri	
36	s after , or ite	y Fu	1 Never Married 2 Married	1 X Yes 2 □ i	No .		specify Cuba s 2∭X No	in, Mexican, Puer Specify:	to Hican, etc.)		Black, White, Specify:	, etc.
8	2 hour stural' cal Ex		3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:		a. Decedent's U	Jsual Occup	ation		16b. Ki	White	
215	within 7; ene. than "n	Completed	(Specify only highest gra	de completed) College (1-4or 5		(Give kind of life. DO NO	work done i	durina most of wo	rking			,
121	filed w Hygier other th		17. Father's Name (First, Middle, Last)	8		lentist		19 Mother's No.	me (First, Middle		al practice	;
lan	Mental l	To Be	Charles W. Hager					Ethel Da		, walden	Sumame/	
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylar it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or iteme 23a or 28a-f ehow or other traumatic event, the Madical Examinar must be notified at		19a. Informant's Name/Relationship	Type, Print)		-		and Number or Ri		er, City o	r Town, State, Zij	p Code)
	1 and Health em 27 ther tr		Mary Jane Hager 20a. Method of Disposition	wife		28 Pine St of Disposition (Fre	stburg Date		laryland	21532
nor	Pages nent of I int: if it		1 Surial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specific		cemet	ery, crematory o	or other plac	1	-Apr-2006		,	aryland
Baltimore,	artm orta		21. Signature of Funeral Service Licen	-	/ Flosio	-		ss of Facility	-Api-2000	110360	uig Wi	шушка
8	Den imp		John The	Wurst				al Home, 57			burg, MD 2	21532
			23a. Part. Enter the disease, or compensor, or heart failure. List only immediate Cause (Final	olications that caused one cause on each li	ne.	_						Approximate Interval Between Onset and Death
).	Physician /Medical		disease or condition resulting in death)	a. + Dio PA	a consequence		TIAL	Puim	ONANY	4-16	("ilan	is mouth)
ı	Examiner		Sequentially list conditions	b		,-						
7	bed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	e of):						
Ć.	execul n and ial-trar	Exan	that initiated events resulting in death) Last	c Due to (or as	a consequence	e of):					-	
68760,	ficate be executed physician and is the burial-transit	edicat		d								
_			IF FEMALE:	23c. If yes, outcome	of prognancy							
Вох	that the death certif ed by the attending detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1⊡Live birth 4⊡Pregnant at	2 Fetal dea	th 3□Ectopia 5□ Other	c pregnancy (specify)			2	23d. Date of deliv Month	ery Day Year
P.O.	at the c	hys	9 Unknown	9□ Unknown								
Ś	w requires that the s been signed by th should be detache		Part II. Other significant conditions of		ut not resulting		ig cause givi	en in Part I.				he cause of death?
Sor	w requ	Completed by	C(E(NIAC)	1914	<u> </u>	1000			24a. Was	Yes 2		bably 4 Unknown
Be	e la has	omp				·			auto	psy ormed?	death?	opsy findings available empletion of cause of
/ital		BeC	25. Was case referred to medical examiner?						1 \ Yes ath Check only o	-	1 🗆 Yes	2 No
€		2	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie	ent 2 ER/C	Outpatient 3	DOA Othe	4 Linursing F			6 □Other (Special	(y)
on	Attending r death. ector: Alter by the funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Da	y Year)	Injury	28c. Injun Worl	Yes 2∐No	28d. Describe	now injur	y occurred	
Division of Vital Record	r Atta	ertification;	3 Suicide 6 Could not be determined	28e. Place of Inj		farm, street, fac	tory, office		28f. Location (Street and	d Number or Rura	al Route Number,
۵	pital o	O	CO. Continue of Continue Di						lo comunications			
	te Hos te Fun	edicai	29a. Certifier (Check only one) Certifying Ph 2 Medical Examone)	ysician: To the best niner: On the basis of and manner st	f examination a	ge, death occur and/or investigat	red at the tim tion, in my of	ne, date and place pinion, death occu	e, and due to the urred at the time,	date and	and manner as s place, and due to	stated. o the cause(s)
	To the Hospital or Attanding Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	Me	29b. Signature and title of certifier	MI	12/7		29c. License	number	1- :	29d. Dat	e signed (Month,	Day, Year)
1	0/100		1 KIlly	M/ 1	(VI)		1	- 55/	(3)	31	131/06	
	MAS		30 Name and address person who	Completed cause of d	eath (Item 23a	(Type, Print)	Ofar	1- ('um so	ala	nd N	1 7 1502
	Sta	_	31. Date filed (Month, Day, Year)		ar's Signature							0.7.
	Registr	ar	APR 0 3 20	UD Alexander	w D.	62346	Ed.					

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2006 0945 M S HARRIS FRANCIS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death & Examiner revol Mea NICHNICO TENINSULA If Under 1 Year If Unger 24 Hrs. 5. Social Security Number 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1**⊠**M 2□ F 235-46-3866 Director DEC 20 1931 WEST Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-1 ehow the Mudical Examiner must be notified at 1 Yes 2 □ No Director VIRGINIA ACCOMACK CHINCOTGAGUE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code , or iteme 23a 23336 4180 ROAD death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 250 Married Maryland 21215-0036 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural" WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 end 2 should be filed within 7:
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other then "ns eny injury or other treumatic event, the M-dic 2006. Elementary/Secondary (0-12) College (1-4or 5+) TRANSPORTATION 12 Th GRADE BRIDGE TENDER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CLINTON U. HARRIS JANET ARMS TRONG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4180 RIDGE ROAD CHINCOTEAGUE, VA. 23336 EMMA SUE HARRIS WIFE Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slate 20a. Method of Disposition CHINCOTEAGUE 1 ☐ Burial 2
Cremation 3 ☐ Removal from State CREMATORIUM OBAFRIL 2006 VIRGINA
22. Name and Address of Facility FOX & HOLSTON FUNERAL HOME OBAPRIL 2006 4 □ Donation 5 □ Other (Specify) ISLAND CREMATORIUM 21. Signature of Funeral Service Licensee CHINCOTEAGUE, VIRGINIA 23536 5049 CHICKEN CITY ROAD n. Dule Tex 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASCVO Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine ettending physicien and for use as the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ed by the e 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by COPD 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CITF 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 1 No 1 ☐ Yes 1 Tyes 2 No After this certification funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 PER/Outpatient 3 DOA 1 Yes Certification: To 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending To the Hospital or Attenum; within 24 hours after death.
To the Funerel Director: Aft 1 TYes 2 TNo investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 5/06 Name and address of person who completed cause of death (Item 23a) (Type, Print) Snyder 100 E. Carroll St. Salisbury, Md. 21801 hris 31. Date filed (Month, Day, Year, State 2006 Registrar

DHMH 17 Rev 1/2001

			1 - For Stete Registrar		State o	f Maryla		artment of rtificate of		id Mental F	lygier Reg. 1	2111)6	12607	
I	Physici	an	1. Decedent's Name (Firs							2. Date of Month	Death	Day	Year	3. Time of Death	_
	/Medic	al	PETER E. HANLON, SR. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of D						APRIL		6	2006	2:40PM ^M	_	
	Examin	er	700 PORT	_				45. City, 10wii,	EASTON	Jeain .	1	tc. County	TALBO	ЭТ	
	Funeral		5. Social Security Number		X ∃M 2□F	7. Age (In yr	rs. last birthday) If Under 1 Year Months Days	If Under 24		Birth Day, Yea	10	9. Birthpl	lace (State or Foreign	7
L,	Director		397-30-7064 Usual Residence of Dece		2M 2UF	87	Yrs.			SEPT.	19	1918	NEW	YORK	_
	yland 10w			County		10c. (City, Town or L	ocation					10	0d. Inside City Limits	-
	e Mar 3a-f sh tiffed	ctor	MD	TALBO	T		EAST	ON						Yes 2 □ No	
	with th	Director	10e. Street and Number					10f. Zip Code			10g. (What Coun	try?	
	death with the Maryland ms 23a or 28a-f show r⊓ust be rotified at	Funeral	700 PORT S'	r., UNI	12. Was Dec	edent Ever in	U.S. 13.	Was Decedent of If Yes, specify Cul	601 Hispanic Origin	? (Specify Yes or	No-		JSA e - America	an Indian,	_
320	thin 72 hours after death with the Marylan e. an "natural", or Itams 23a or 28a-1 show Madical Examinat must be notified at	by Fur	1 Never Married 2		Armed For 1 X Yes If Yes, Giv Year or D	2 □ No ve		If Yes, specify Cul 1 ☐ Yes The Notice of the Property Culture of the Prop		Puerto Rican, etc.)			ck, White, e		
2-003p	72 hou nature		15. E	Decedent's Edu ly highest grad	ication		16a. Dece	edent's Usual Occu	ipation	f working	16b.	Kind of Bu	usiness/Ind	ustry	-
Z	within ene. than "I	Completed	Elementary/Secondary		College (1-4or 5+)	life.	DO NOT use retire	ed)	working.		1000			
20	filed Hygi thar int.		12. Father's Name (First,	Middle, Last)	5+		PI	IYSICIAN	18. Mother's	Name (First, Midd	ile, Maid		CINE		_
yland	a d la la la la la la la la la la la la la	To Be	PETER E.						CELE	STINE LO	UNEY				
Mary	s 1 and 2 should f Health and Men itam 27 Is marke other traumatic	_	19a. Informant's Name/P					ing Address (Stree						Code)	_
e, ≧	l and health		PETER E. H.		JR./SO			1 WOODLA osition (Name of	ND DR.,	EASTON,	-				_
altimore			20a. Method of Disposition 1 Burial 2 Cre 1 Donation 5	mation 3 🗆 I		State	cemetery, cre	contion (Name of or other place) CEMETERY		21/2006		XFORE	City or To	wn, State	
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral	Service Licens	Slan	-/		2. Name and Addr ELLOWS, 00 S. HA		EIN & NE	WNAM	FUNE	RAL I	HOME PA	
Г			23a. Part1. Enter the dis shock, or heart failu	ease, or comp	lications that one cause on e	caused the de	eath. Do not en	iter the mode of dy	ing, such as car	rdiac or respiratory	arrest,	MD ZI	UUI	Approximate Interval Between	_
	Physician		Immediate Cause (Final disease or condition	222	. Ch.	runic	Rena	Failu	re					Onset and Death	
	/Medical Examiner		resulting in death)			(or as a cons								10,-	
L		e	Sequentially list condition if any, leading to immedia	ns, ate	V	or as a cons							-	1 2 years	_
	cuted nd ransit	Examin	Cause. Enter Underlying Cause (Disease or injury that initiated events	1	c										
Ď,	ficate be executed g physician and ss the burial-transit		resulting in death) Last	- 1	Due to	(or as a cons	equence of);								
28/60	icate t physic	edicai		•	d										_
ROX		n/Me	IF FEMALE: 23b. Was decedent preg	nant	23c. If yes, ou			75				23d. Dat	te of delive	ry	
_	e death he atte ied for	Physician/M	in the past 12 month	ns?		ointh 2 □ Fe nant at time o own		□Ectopic pregnand □ Other (specify) _	су		-	Мо	nth	Day Year	
J.	hat the		9 ☐ Unknown Part II. Other significant	conditions co			resulting in the	Inderlying cause o	iven in Part I	23e. Di	d tobacci	use cont	ribute to the	e cause of death?	_
ras,	n requires that the de been signed by the s should be detached	ed by	osteourt							1[Yes	2×40	3 🗆 Proba	ably 4 Unknown	
Vital Hecords,	sician: The law requires that the death cert certificate has been signed by the attending irector, page 2 should be detached for use	Completed								ре	topsy rformed2	, E	prior to condeath?	osy findings available appletion of cause of	
Iga		Be Co	25. Was case referred to	medical					26. Place of	1 ☐ Yes Death (Check onl		10	I □ Yes		_
OI <	Physic this ce al direc	ပ္	examiner? 1 ☐ Yes 2 No				☐ ER/Outpatie	IN 3 DOA		ng Home 5□Re				LIVING	
	ding Ph h. After th funeral	tion:		Pending investigation	28a. Date (Mon	of Injury th, Day Year)	28b. Time o	Wo	uryat ork?]Yes 2 □ No	28d. Describ	e how in	jury occurr	ed		
DIVISION	l or Attandii after death. Diractor: A in by the fu	Certification:		Could not be determined	28e. Place	of Injury - At	t home, farm, si	treet, factory, office		28f. Location	(Street	and Numb	er or Rural	Route Number,	_
ā	Hospital or Attanding Physician: 4 hours after death. Funaral Diractor: After this certific tely filled in by the funeral director.	Cert	4 Homicide		Dulla	ing, etc. (Spe				City or	Town, Sta	1(0)			
	la Hospital 1 24 hours a le Funaral	edicai	29a. Certifier 12 (Check only 2 1)	Certifying Phy Medical Exam	iner: On the b	e best of my k asis of exami ner stated.	knowledge, dea ination and/or in	th occurred at the threat the threat	time, date and p opinion, death o	lace, and due to the control occurred at the time	e, date a	(s) and ma nd place, a	nner as sta and due to	ited. the cause(s)	
	To tha within 2 To the complet	ž	29b. Signature and title of	f certifier		10-0			se number		29d. E	ate signed	Month, E	lay, Year)	
			- Imag	2. D. 2		1.4			2816)	7	1	106		
0	+IVA)		IN. I.	1200ms	< 55.	5 C	yn Wood	/	EA	124cM	<i>M</i>)	216	0/		
	Sta Registr		31. Date filed (Month, Da	R 1 1 2	2006 32. F	le strar's Sig	greature	Small s							

06-02415							
Jenkins, Mary							

riease Typ	de di Print in black ingelible ink
State of Maryland /	Department of Health and Mental Hygier

,	1- For Stat . Registrar	Ce	rtificate of Death	and montan	rygiciic Re	eg. No.	6 1260
Physician	Decedent's Name (First, Middle)	·			2. Date of Deat Month	Day Year	3 Time of Death 17:05
edical Examin	Mary 4a. Facility Name (if not institution	Kay Jenkins		vn, or Location of Deat	April 8, 20	4c. County of D	
Š.	22 North Huron Street	, give street and namber)		Heights		Prince Geo	
Funeral	5. Social Security Number	5. Sex 7. Age (In yrs.	• • • • • • • • • • • • • • • • • • • •				. Birthplace (State or Forei
Director	228-64-9545	1 M 2X F 59	Yrs. Months	Days Hours Mi	03/2	5/1947	N.Y.
any	Usual Residence of Decedent 10a State 10b, County	10c. City	, Town or Location				10d. Inside City Limit
*	MD. P.G	· ·	orest Hgts	•			1 X Yes 2 N
he Maryland a or 28a-f sh ified at once	10e. Street and Number		10f. Zip C	ode	10	g. Citizen of What (Country?
th the Maryland 23a or 28a-f show notified at once.	22 North H	uron Street	20	745		U.S.A.	
filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once.	11. Marital Status	12. Was Decedent Ever in U		of Hispanic Origin? (S Cuban, Mexican, Puert		14. Race - Al White, et	merican Indian, Black,
er deat , or its		1 Yes 2 No		No specify:	,		√hite
urs aft tural" amine	45 December May 1961 1961	or Dates: fy only highest grade completed)	16a. Decedent's Usual Oc		work done	16b. Kind of Busine	
72 hou "na al Exa	Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle, t	College (1-4 or 5+)	during most of working life.	DO NOT use retired)			
21215-0036 Juld be filed within 72 Mental Hygiene. marked other than 'e event, the Medical	12th		HR Specia	*		Govern	nment
filed v I Hygi sd oth		•		_	ne (First, Middle, N	,	
2121! Jid be fill Mental H marked event, 1	19a. Informant's Name/Relationshi		19b. Mailing Address	1	erine B		State, Zip Code)
2 shot and 27 is mati	John Jenkin		3800 Saxt				
	20a. Method of Disposition		Place of Disposition (Name crematory or other place)	of cemetery,	Date	20c. Location - Cit	y or Town, State
imore, N Pages I and I ment of Health ant: If item or other trau	4 Donation 5 Other Spe	P.	verdale Pa	rk 4,	/13/06	Riverd	dale, Md.
Baltimore, permit. Pages I an Department of Hea Important: If iter injury or other tra	21. Signature of Funeral Service L	icensee	22. Name and Ad	dress of Facility	eral Ch	apel. Ir	IC.
	23a Part I. Enter the disease, or o	omplications that caused the death	814-	Upshur St	reet,	N.W.	Approximate Interv
Physician /Medical	failure! List only one cause of	n each line.	i. Do not enter the mode of	Tyring, such as cardiac	or respiratory arre	sat, shock, of fleat	Between Onset an
Examiner	Immediate Cause (Final disease or condition resulting in death)	a. Atherosclerotic Due to (or as a consequence of	cardiovascular (lisease			
-	Sequentially list conditions,	b.					
red nsit	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of	of):				
d d	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	of):				
		d.	Ba,PII,27,perMe,s	051. 1.101.106	TTT		
4) 77 -	IN UNPENDED			30.54,4/24/00	11		
		23c. If yes, outcome of preg	gnancy 2 Fetal death	3 Ectopic pregr	nancy	23d. Date of deli Month	Day Year
Records, P.O. Box 68 The law requires that the death certif tate has been signed by the attending tage 2 should be detached for use as	1 Yes 2 No 9 V Unkr	4 Pregnant at time of do		/)			
the de charter of the	- Part II. Other significant condition	a Cuklowii	resulting in the underlying c	ause given in Part I.	23e. Did to	bacco use contribute	e to the cause of death?
P.O. res that the signed by be detach		•		3			Probably 4 🗸 Unknown
cords, law requir has been s	Diabetes mellitus				24a. Was a		e autopsy findings availab
e law te has ge 2 sh					autop:	med? deat	
L			26	Place of Death (Check	1 ✓ Yes : k only one)	Z NO I	Yes 2 No
f Vital Physician er this certi	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 DO	Other Nurs	ing Home 5	Residence 6 🗸 C	ther: Scene
of Vital Recing Physician: The After this certificate funeral director, page	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28	. Injury at Work?	28d. Describe h	ow injury occurred	
Sior Attend r death ector: by the	2 Accident Pendi	igation		Yes 2 No			
Division of Vital Records, Hospital or Attending Physician: The law requir 44 hours after death. Function: After this certificate has been s fell find by the funeral director, page 2 should	determ	not be	nome, farm, street, factory, o	ffice building, etc.	28f. Location (S or Town, S		r Rural Route Number, Cit
bou hou		ysician: To the best of my knowled	dee death occurred at the ti	me date and place an	d due to the caus	e(s) and manner as	started
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	(Check only	niner: On the basis of examination	_				
F S S	29b. Signature and title of certifier	and manner stated.	29c. l	icense number		29d. Date signed	(Month, Day, Year)
	Pot () m	11-4000e		D.C.M.E.		April 9, 2006	
		who completed cause of death (Iten	. '				
العصيا	Patricia Aronica-Pollak			n Street, Baltimo	ore, MD 21201		
Sta Registr		7 2006 32. Ragistrar's Signat	the Apolle				
rtegioti		program .	7				

ORIGINAL

DHMH 17 Rev 1/2001 OCME 10/2003

AEM 06-02219 Johr

n l	Robert	Jud	State of Maryland / Dep		•	•	10000
			_ F0f	rtificate of Death		2000	12603
			Negistrar 1. Decedent's Name (First, Middle, Last)		2. Date of Death	. No.	3. Time of Death
	Physicia			ludy	March 3	1. 2006	9:45 A M
5	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	Adiiiii		13141 Warrior Drive	Cresaptown		Allegany	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birthp	ace (State or Foreign try)
	Director		214-32-3032 /0		10/02/19	935 Mary	land
	and		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		1	Od. Inside City Limits
	Mary -f sh	to	MD Allegany	Cresaptown			1 ☐ Yes 2 🖔 No
	r 28a	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Coun	try?
	th wit	aiD	13141 Warrior Drive	21502		USA	
	ems.	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13.	Was Decedent of Hispanic Origin? (Spell Yes, specify Cuban, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	s afte , or if	by Fu	1 Never Married 2 Married 1 Yes 2 No 11 Yes, Give 3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 🖾 No Specify:		Specify:	<i>l</i> hite
9	within 72 hours after death with the Maryland liene. I then "natural", or items 23a or 28a-f show then "matural" or items 23a or 28a-f show the Madical Examiner must be notified at		15 Decedent's Education 16a Dece	edent's Usual Occupation	16	bb. Kind of Business/Ind	
15	in 72	piet	(Specify only highest grade completed) (Give life. Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of workii DO NOT use retired)	ng		,
212	d within giene. ir then	Completed	12	Clerk	W	holesale Fo	oods
b	be filed tal Hygi d other	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name			
yla	2 should be and Mental is marked of raumatic ev	၉	Carmy Rudolph Judy	Anna	Le		nhart
Baltimore, Maryland 21215-0036	ges 1 end 2 should be filed to f Heelth and Mental Hyg If item 27 is marked othe or other traumatic event,			ing Address (Street and Number or Rura		1980	
e,	es 1 end 2 of Heelth a fitem 27 is r other tra			9 McGill Drive, Cu		Mary Land C. Location · City or To	
סַכ	Pages nent of h int: if ite		1 M Buriai 2 Cremation 3 Memoval from State	osition (Name of ematory or other place) 1 Cemetery 04/07		Cumberland,	
菲	it. Perturber		. 255				Home, P.A.
Ba	permit. Page Department of Important: if any injury or once.			404 Decatur Street			21502
			23a, Part1. Enter the disease, or complications that caused the death. Do not en	nter the mode of dying, such as cardiac of	r respiratory arres	t,	Approximate fnterval Between
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	- CAMIONASUL	A. DI	- SAR-	Onset and Death
	/Medical		disease or condition resulting in death) a. AT WE 100 S (2011) Due to (or as a consequence ol):	- ()300(0V)3300C	ISIC VI	SEW XP	
п	Examiner		Sequentially list core little is				
	D #	iner	Gequentitally list curiuitluis, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	be executed icien and burial-transit	Examiner	resulting in death) Last C. Due to (or as a consequence of):				
760,	le be executed ysicien and e burial-transit	cal E					
687	h certificate t ending physi use as the b		d	a restriction of the second			
Box	death certificat e attending phy id for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of delive	iry
	deat e att	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5	Other (specify)		Month	Day Year
P.0	\$ ≥ ≥	Phys	9 Unknown		an Didust		
	res thai igned to be det	ρ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part t.		cco use contribute to the	ably 4 ⊟Unknown
of Vital Records,	w requir been si should	Completed					
3ec	e law has t	mpi			24a. Was an autopsy perform	24b. Were auto prior to con death?	psy findings available apletion of cause of
alF					1 Yes 20	SHio 1 ☐ Yes	2□ No
Σ	sicial	o Be	25. Was case referred to medical examiner? 152 'ys 2 □ No Hospital: 1 □ Inpatient 2 □ EFVOutpatie	26. Place of Death ent 3 DOA Other: 4 Nursing Ho		ce 6 X Other (Specif	Scene
ō	Phys or this oral di	-	27. Marrier of Death 28a. Date of Injury 28b. Time		28d. Describe how		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Division	nding F ith. r: After e funera	atio	1 Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	M 1 Yes 2 No			
Vis	or Attendi efter death. Director: A in by the fu	ific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, s building, etc. (Specify)	treet, lactory, office	28I. Location (Stre City or Town,	et and Number or Rura State)	l Route Number,
Ö	rs efter al Dire ed in by	Certification:	building, etc. (opposity)				
	To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: After this certifical completely filled in by the funeral director, I	edicai	29a. Certifier (Check only Medicat Examiner: On the basis of examination and/or in	ith occurred at the time, date and place, nvestigation, in my opinion, death occurr	and due to the cau ed at the time, dat	se(s) and manner as s e and place, and due to	tated. the cause(s)
	To the P within 2. To the F complete	Med	one) and manner stated.	29c. License number		d. Date signed (Month,	
			29b. Signifure and title of certifier	OCME	230		1, 2006
	3		and address of a second desired and a second desired and a second desired as a second			whiii	1, 2000
	nes		30. Name and address of person who completed cause of death (Item 23a) (Type YAMA CORFW	111 Penn Street	Baltimor	e, Marylan	d 21201
	Sta	ate	13, 10, 3				
	Regist		APR 0 5 2006	Pocale			

mended Line	2 , pe	T ForMD, TOHD, 4/17/06, SbbState of Maryland / Dep State Registrar Ce	artment of Health and rtificate of Death		2006	12610
Dhyoi		Decedent's Name (First, Middle, Last)			April 4,2006	3. Time of Death
Physic /Med		Joyce Kathleen Jones		March	4 2006	20/3 "
Exam		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea		4c. County of Death	
		THE MEMORIAL HOSPITAL	EASTON		TALE	30 T
Funera		5. Social Security Number 6. Sex 1 M 2 K F 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs Months Days Hours Min		ear) 9. Birthp	lace (State or Foreign
Directo		217-42-5641 61		July 26,	1944 Mary	Land
iand iand		10a. State 10b. County 10c. City, Town or Li	ocation		1	0d. Inside City Limits
h the Maryland ir 28a-f ehow	ğ	Manual - I David - I Cold - I				1 Yes 2 □ No
288.	Director	Maryland Dorchester Cambridg	e 10f. Zip Code	100	. Citizen of What Cour	ntry?
3 or		827 Fairmont Ave.	21613			,
death ms 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (S	Specify Yes or No-	USA 14. Race - Americ	an Indian,
11215-0036 within 72 hours after death with the Maryland ene. then "naturel", or items 23e or 28e-f ehow he Madical Exerties must be notilized at	Fu	1 Never Married 2 Married 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	Black, White,	etc.
215-0036 thin 72 hours affile naturel; or	by	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify:	lack
5-0	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of wo	16	b. Kind of Business/Inc	
2 iii	du	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	iking		
O = = =	် ပြ	1 Re	ceptionist		Shore Up	
be filed y and other went, it	Be	17. Father's Name (First, Middle, Last)	18. Mother's Na	me (First, Middle, Ma.	iden Sumame)	
aryland should be f nd Mental I	2	James I. Jones	Marze	lla Ander	son	
0 0 0		19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Street and Number or R	ural Route Number, C	ity or Town, State, Zip	Code)
Te, M 1 and 2 Health tem 27			4 Egypt Road, Car	mbridge, Ma	ryland 216	13
or Herritarios		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition cemetery, cre	osition (Name of matory or other place)	Date 20	c. Location - City or To	wn, State
Pag Pag nent ant: P			. Church Cem. 04-0	08-2006	Cambridge,	Marvland
Baltimore, permit. Pages 1 a Department of Hea importent: if item			Name and Address of Facility		oumbildge,	ial y land
a 88.55		June Jal	Bennie Smith Fune 524Race Street,	eral Home Cambridge.	Maryland 2	1613
		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardia	c or respiratory arrest	,	Approximate Interval Between
Physician		Immediate Cause (Final	<i>C</i>			Onset and Death
/Medica		resulting in death) a. The following in death) Due to (or as a consequence of):	my Cavinoma			smorth 5
Examine			9			
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60, be executed icien and burial-translt	Examiner	Cause (Disease or injury that initiated events c.				
60, be exe		resulting in death) Last Due to (or as a consequence of):				_
8760, sate be executed oblysicien and the burial-transit	dical	d				
	Aed	IF FEMALE.				
of Vital Records, P.O. Box 6. Physician: The law requires that the death certificate has been signed by the attending priad director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □	Ectopic pregnancy		23d. Date of delive	iry
deal deal he att	SICIO	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month	Day Year
P.O. that the de ed by the detached	hy	9 🗆 ORKROWN				
S, F es tha gned be de	by	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	co use contribute to th	e cause of death?
cords, v requires been sign	ed	Pulmonary embolism		1X Yes	2 No 3 Prob	ably 4 □Unknown
as becased	Completed			24a. Was an	24b. Were autop	osy findings available appletion of cause of
I Re(The lav	E			autopsy performe	d? death?	
Vital F ician: Th certificete rector, pag	a)	25. Was case referred to medical	26 Place of De	1 ☐ Yes 2 ☑ ath (Check only one)	No 1 ☐ Yes	2 No
Division of Vital Records, or attending Physician: The law requires the after death. Director: After this certificate has been signe in by the funeral director, page 2 should be a	To B	examiner? 1 ☐ Yes 2 ☑ No Hospital: t ☑ Inpatient 2 ☐ ER/Outpatien	Othor		e 6 Other (Specify	4)
g Physer this		27. Manner of Death 28a. Date of Injury 28b. Time of		28d Describe how		7
Vision Attending r death. ector: After by the fune	atlo	1) Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	M 1 Yes 2 No			
ViS Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, steep the suiting sets (Specify)	eet, factory, office	28f. Location (Stree	et and Number or Rura	l Route Number,
S after solution of in	Cer	4 Homicide Setermined building, etc. (Specify)		City or Town, S	rare)	
ospii hour uneri ly fills	<u>a</u>	29a. Certifier 10 Certifying Physician: To the best of my knowledge, deat	occurred at the time, date and place	and due to the caus	se(s) and manner as st	ated.
Division of To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edical	(Check only 2 Medical Examinar: On the basis of examination and/or in one)	vestigation, in my opinion, death occi	irred at the time, date	and place, and due to	the cause(s)
To the within 2 To the complet	Σ	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, I	Dey, Year)
		> TX Shell Stated has	1) 4722	2	nular-1.	anla
5 -		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)		04/05/2	2000
- 5 -		Sog Idlewid Arene	Print) Ec. Ston. N	11) 2160	. /	
100 %	tate	31. Date filed (Month, Pay, Year) 32. Registrar's Signature	10		-	
Regis	trar	MELL O (ZOND)	13.37			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieneo or

			1- For State of Maryland / Depar Registrar Certif	tment of Health and M ificate of Death		ene 2006	12611
	Physici		1. Decedent's Name (First, Middle, Last) Carrie I. Kuykendall		2. Date of Death Month	Day Year	3. Time of Death
ST.	/Medic Examin			4b. City, Town, or Location of Death Emmitsburg		4c. County of Death Freder	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month, Day, 1-13-	9. Birth	place (State or Foreign intry) encastle, P.
	D.	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loca PA Adams Fairfie				10d. Inside City Limits 1 ☐ Yes 2 🕍 No
	with the	Direc	10e. Street and Number 215 Old Waynesboro Rd.	10f. Zip Code 17320	10	g. Citizen of What Cou USA	intry?
36	filed within 72 hours after death with the Maryland Hygiene. uther than "natural" or Items 23a or 28a-1 show ont, the Medical Exerting regal for incilling at	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	as Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify: Wh	, etc.
21215-0036	within 72 hoursine.	Completed t	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1·4or 5+)	nt's Usual Occupation ind of work done during most of working NOT use retired) Dry Worker	ng	6b. Kind of Business/Ir	ndustry
	ld be filed vental Hygie ked other tic event, II	To Be Co	17. Father's Name (First, Middle, Last) Earl Mickey	18. Mother's Name		aiden Sumame)	cessing
ore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Exaction arrival by notified at once.	-	Joyce Corl, Daughter 215 C 20a. Method of Disposition 12 Burial 2 Cremation 3 Removal from State 20b. Place of Disposit cemetery, crema	atory or other place)	Rd., F	airfield Oc. Location - City or T	PA 17320 own, State
Baltimore,	permit. Pag Department Important: any injury o		4 Donation 5 Other (Specify) Oak Lawn 21. Signature of Funeral Service Licensee 22. N	Mem. Gard 4-17 Name and Address of Facility 525 Bradbury Av	JL Davi	Gettysburg s Funeral	L Home
8760, \	/Medical Examiner but sician and but sician and the burial-transit	dical Examiner	23a. Part / Engr / the disease, or complications that so he death. Do not enter show, or the art failure. List only one cause of a continuous failure. List only one cause of a continuous failure. List only one cause of a continuous failure. List only one cause of a continuous failure. List only one cause of a consequence of a continuous failure fai	the mode of dying, such as cardiac o	or respiratory arres	st,	Approximate Interval Between Onset and Death
.O. Box 68	death certifi e attending id for use as	by Physician/Med		Ectopic pregnancy Other (specify)		23d. Date of deliv Month	ery Day Year
Vital Records, P.	e law requires has been sign je 2 should be	Completed by Ph	Part of Other significant conditions contributing to death but not resulting in the und	erlying cause given in Part I.	1 ☐ Yes 24a. Was an autopsy perform	24b. Were autoprior to codeath?	bably 4 Unknown opsy findings available ompletion of cause of
Division of Vital	To the Hospital or Attending Physician: Th within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag	Certification: To Be Co	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 3 Suicide 6 Could not be determined 4 Homicide 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	28c. Injury at Work? M 1 Yes 2 No	n (Check only one me 5 Residen 28d. Describe hov	oce 6 Other (Speci	fy)
۵	To the Hospital o within 24 hours aft To the Funeral Di completely filled in	edical Cer	29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigations)		and due to the cau	use(s) and manner as s	
l l	To the vithin 2 To the complet	Med	29b. Signature and talle of certifier	29c. License number	29	d. Date signed (Month,	Day, Year)
,	. 6		30. Name and address of person who completed cause of death (Item 23a) (Type, Pr Dr. Alan Carroll, 310 S. Seton A	nint) Ave., Emmitsbu	rg, MD	21727	Ψ
	Sta Registi	-	31. Date filed (Month, Day, Year) APR 2 1 2005 32 Polistrar's Signature	E STATE OF THE STA	J,		

DHMH 17 Rev 1/2001

		•	For State Registrar	State of Ma	aryland	-	artment of <i>tificate of</i>				ene) () (6	12612
			1. Decedent's Name (First, Middle, Last)							2. Date of Death Month	Day	Year	3. Time of Death
	Physicia /Medic		POLINA I. KUPENSK	AYA						APRIL 4		, 50	11:15 P M
7	Examin		4a. Facility Name (If not institution, give str	reet and number)			4b. City, Town,	or Location	of Death		4c. County	of Death	
			HEBREW HOME OF GE				If Under 1 Yea		CVILLI or 24 Hrs.				GOMERY
	Funeral Director		5. Social Security Number 6. Sex	7. Age	91	Yrs.	Months Day			8. Date of Birth (Month, Day,) OCT • 1,		UKRA	place (State or Foreign ntry) ATNF
			346-80-6417 Usual Residence of Decedent		71					001. 1,	1714	ORIG	IIIID
	ylanc		10a. State 10b. County		10c. City,	Town or Lo	cation					1	10d. Inside City Limits
	Mar.	ģ	MARYLAND MONTGOM	IERY			ROO	CKVIL	LE				1 □XYes 2 □ No
	th the	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of W	/hat Cour	ntry?
	23s	la [5121 MONTROSE ROAD					2085				U.S.	
	ar de	Funeral	11,110,1110	2. Was Decedent 8 Armed Forces?		. 13. \	Was Decedent of f Yes, specify Cu	Hispanic C ban, Mexic	rigin? (Spe an, Puerto I	ecify Yes or No- Rican, etc.)		e - Americ k, White,	can Indian, etc.
30	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. do ther then "natural", or itams 23a or 28e-f ehow event, tra Medical Evaninar must be notified at event, tra Medical Evaninar must be notified at	by F	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 📉 N If Yes, Give Year or Dates:	40		1 ☐ Yes 2X N	o Specif	y:		Specify	:	WHITE
21215-0036	2 hou	led	15. Decedent's Educa	ation		16a. Deced	dent's Usual Occ	upation		11	6b. Kind of Bu	siness/In	idustry
ה ה	hin 7.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5	+)	life.	kind of work don DO NOT use retir	e during mi red)	ost of workii	ng			
Z	or the	Com	, , , , , , , , , , , , , , , , , , , ,	4			JOURI	NALIS'	Г		PU	BLIC	CATIONS
2	~ - 0 5	Ø.	17. Father's Name (First, Middle, Last)							(First, Middle, Ma	aiden Sumam	e)	
Z	should be nd Mental marked o	၉	ISRAEL KUPENSKY			401-14-11				REKHTER	2'h T	Ot- 4- 7/	0-1-1
Maryiand	12 st h and 7 le m traum		19a. Informant's Name/Relationship <i>(Typ</i> i ALLA LUBINSKY/DAUGHT				3			ALEXANDR			A 22310
	permit. Pages 1 and 2 should be Department of Health and Menia Important: It Item 27 Ie marked any injury or other traumatic evonce.	1	20a. Method of Disposition		20b. Pla	ce of Dispo	sition (Name of	1			Oc. Location -		
	Pages nent of int: It it		ty□ Burial 2 □ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify)	moval from State		•	natory or other p	. 1	04/07	7/2006	LNEY,	MARV	T AND
altimore,	artme ortan injur		21. Signature of Funeral Service Licenses		OODL					DIRECT			LAND
ă	Den Imp		Donald ()	Total	mye	ع (ED	WARD SAG 91 ROCK	GEL FO VILLE	JNERAI PIKE,	L DIRECT] . ROCKVII	ION, IN LLE, MA	IC. LRYLA	ND 20852
8			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused	the death.	Do not ent	er the mode of d	ying, such a	as cardiac o	r respiratory arres	st,		Approximate Interval Between
	nysician i	i i	Immediate Cause (Final disease or condition	Athenna	closes	fir Co	rduvasc	ular	No sec	N		- 1	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	100		1	Maria Care	- Charles	- Article			1
	Lxaiiiiiei		Sequentially list conditions, b.	Due to (or as	4 11	tory	Museun					_	gears
	ped ised	nlner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Alexand L	onseque	STICE DIV						130	1 Wall
	ad-tran	Examin	that initiated events c. resulting in death) Last	Dig to (or as	a conseque	ence of):							year
8/60	cate be executed physician and the burial-transit	dical E	d.										<i>V</i>
0	tificat ng ph) as th	a a											
ROX	death certifica s attending pl d for use as t	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome 1 □ Live birth			∃Ectopic pregnar	ncy			23d. Date Mor		ery Day Year
	The law requires that the death certify the has been signed by the attending tage 2 should be detached for use as	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of dea	ath 5	Other (specify)				NIO		Day Tour
л Э	hat th od by detacl	Ph)	Parall. Other significant conditions cont	ributing to death b	ut not result	ting in the u	nderlying cause o	niven in Pai	11.	23e. Did toba	icco use contr	ibute to t	the cause of death?
ďS,	w requires that s been signed t should be det	d by	fremerone.					,,,,,,,,,		1 ☐ Yes	2 □ No	3 🔲 Prot	bably 4 DUnknown
Vital Records,	v requ been shoul	ete	ALLOUID							24a. Was an	24b V	Vara auto	opsy findings available
Ř	he law s has ge 2 ;	Completed	De 1			-				autopsy perform	edi? d	rior to co leath?	empletion of cause of
ē	ilcian: Th certificate rector, pag	Ö	25. Was case referred to medical	1				26 Pla	ce of Death	1 Yes 2		Yes	2L No
	Physician: rthis certific ral director,	To Be	examiner?	spital:	nt 2□E	R/Outpatier	nt 3 DOA			me 5 🗆 Resider		er (Specii	fy)
0	ding Phys	L:u	27. Manner of Death	28a. Date of Inju (Month, Da		28b. Time o Injury	f 28c. In			28d. Describe hov			
<u>0</u>	Attending ir death. ector: After by the funer	atlo	2 Accident investigation			. ,	M 1	☐Yes 2	□No				
DIVISION OF	or Att	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injuding, et			reet, factory, offic	e		28f. Location (Stre City or Town,		er or Rura	al Route Number,
_	Hospital or Attend 24 hours after death Funerel Director: tely filled in by the		29a. Certifier Certifying Physi	nien. To the head	n4 mu l	indan da-t	h occurred at the	time det-	and place	and dup to the	100(0) 0=======	2005.22	atata d
		edical	29a. Certifier (Check only one) Certifying Physical Examin-	er: On the basis of and manner sta	examination	on and/or in	vestigation, in my	y opinion, d	eath occurr	ed at the time, da	e and place, a	and due t	o the cause(s)
	To the within 2 To tha complet	Me	29b. Signature and title of pertifier				29c. Lice	nse numbe	r	29	d. Date signed	(Month,	Day, Year)
	5		1/1/Km	111			100	1352	87		4/5/00	0	
	of the same of the		30. Name and address of person who con	npleted cause of d	eath (Item :	23а) (Туре.	Print)	1. 1	1,	1/	7	7	
_			Aubrely Knight	110 10	2/1	lank	Sc KO	, to	ekul	u, MI	2085	4	
	Sta Registi		31. Date filed (Month, Day, Year)	32. Progistr	ar's Signatu	F. A	garle "						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year 1:48 P **Physician** 31, 2006 March Richard Kosch /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Bethesda 8503 Rayburn Road ff Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. June 12, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1929 1 X M 2 □ F June Nebraska 76 Yrs. Director 506-28-7611 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County 10a State 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 □ No Maryland Montgomery Bethesda Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20817 8503 Rayburn Road filed within 72 hours after death Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No Korean It Yes, Give War Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Efementary/Secondary (0-12) other than I.B.M. Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Depertment of Heelth and Mental Hy Important: if Item 27 is marked oth any Injug or other traumatic event one. Be Anna Reimann William H. Kosch .0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8503 Rayburn Rd. Bethesda, Maryland 20817 Mary Clare Kosch -Wife Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Metropolitan April 2006 1 Burial 2 Cremation 3 Nemovat from State Alexandria, Virginia Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., N.W. Washington, D.C. 20007 21. Signature of Funeral Service Licensee Eny & 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Brain Tumor **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit attending physicien and Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical d IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ed by the a 9☐ Unknown this certificate hes been signed by rail director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 1 ☐ Yes 2 X No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
Yes 2 2 No 1 ☐ Yes 2 ☐ No 1□ Yes 26. Place of Death (Check only one) After this certific funeral director, 25. Was case referred to medicat Be examiner? Hospital: 1 | Inpatient 2 | ER/Outpatient Other: 4 ☐ Nursing Home 5 \$\infty\$ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No 3 DOA 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 1 X Natural 5 Pending 1 Yes 2 No death. investigation 2 Accident the Director 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 \ Homicide within 24 hours efter ö 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10 D23127 April 3, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #925 5530 Wisconsin Ave. Chevy Chase, MD 20815 Kevin G. Nealon, M.D. 31. Date filed (Month, Day, Year) 32. ** Signature State 0 6 2006

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 6 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Year MILDRED LOUISE KLINE 15: 20 M 06 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CUMBERLAND ALLEGANY SACRED HEART HOSPITAL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1 ☐ M 2 🔀 F 97 July 14, 1908 236-66-1722 WV Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. fnside City Limits Hampshire 1 ☐ Yes 2 X No Paw Paw 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? HC 60, Box 9AA 25434 **USA** 11. Maritaf Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No ff Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: 3 Widowed 4 □ Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Benjamin H. Kline Emma Bell Bougher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Maggio - Daughter HC 60, Box 9AA Paw Paw. WV 25434 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Camp Hill Cemetery April 2,2006 Paw Paw, WV 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kimble Funeral Home Paw Paw, West Virginia 13a. Part \ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Daverticulities Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2□ No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitaf: 1 ☐ Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28b. Time of fnjury 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturaf 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-tran Box 68760 Division of Vital Records, P.O. certificete After this certific funeral director, death. efter death Director: / I in by the f 24 hours efter Funeral Dire within 24 hor To the Fune completely fi To the 6

Physician

/Medical

Examiner

Completed by Funeral Director

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Examiner

Physician/Medical

Completed by

Be

Certification; To

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

MES

man 30. Name and address of person who completed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show eny injury or other traumetic event, ira Modical Examinar Insulate notitied at ODEs.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0036

nes

DHMH 17 Rev 1/2001

State Registrar

32. Registrates Signature 31. Date filed (Month, Day, Year) APR 0 7 2006

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

tuse of death (ftem 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** April 10, 2006 5:20 A Kimble Dwight /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 12208 Valley Road Allegany Cumberland If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 X M 2 ☐ F Yrs. 201-38-9914 04/26/1947 Director 58 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits show 10a. State r than "natural", or itams 23a or 28a-f show the Medical Evarriner must be notified at 1 ☐ Yes 2 ☑ No MD Directo LaVale Allegany 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11113 New York Avenue 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 XYes 2 No If Yes, Give Vietnam Year or Dates: Era 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: ğ 3 ☐ Widowed 4 ☑ Divorced White Era Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Retail Store 12 Owner and Operator ges 1 and 2 should be filed v t of Health and Mental Hygie ff itam 27 is merked other? 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Kimble Evelyn Elaine Crabtree David Denver 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Daniel Knight / Friend 11113 New York Avenue, LaVale, Maryland 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 X Buriai 2 ☐ Cremation 3 ☐ Removal from State ō permit. Page Department of Important: If any injury or once. ` 4 ☐ Donation 5 Other (Specify) Bethel Cemetery 04/13/2006 Bedford, PA 21. Signatury of Fur eral Service Licenses 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Kenu Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease o. Injury that initiated events Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) the hed i 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Minknown been si Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has certificate 1□ Yes 2□,No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Cther: 4 Nursing Home 5 Residence 6 Nother (Specify)Residence Hospital: 1 ☐ Yes 2 ☐ No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) Diractor: After that in by the funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Within 24 hours are To the Funaral Dir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number April 10, 2006 5 D36766 IVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) pel 924 Seton Drive, Cumberland, Maryland 21502 Vik Poonai, M.D., 32. Registrar's Signature 31. Date filed (Month, Day, Year) State mock. APR 1 0 2006 ENS. Registrar

			Trease 1	State of Ma							•		-	o.	10616
		•	1 - State Registrar		•	•		e of L				Reg.		b	12010
	Physicia	20	1. Decedent's Name (First, Middle, Last)								2. Date of Month		Day	Year	3. Time of Death
	/Medic	_	Norma Karlin						1		April	5,	2006	-10 "	11:45P M
	Examin	er	4a. Facility Name (If not institution, give s	street and number)				ville	Location o	or Death			4c. County Montg		
	Funeral		Casey House 5. Social Security Number 6. Sex		(In yrs. la	ist birthday)	If Unde	r 1 Year	If Under		8. Date of (Month,				hplace (State or Foreign untry)
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and	be fill bd ott	Be	17. Father's Name (First, Middle, Last) David Miller								hbein	die, Mai	den Sumam	θ)	
Maryland 21215-0036	thould od Mer mark matic	ဥ	19a. Informant's Name/Relationship (Ty	pe, Print)	-	19b. Mailin	g Addres	s (Street a				mber, C	ity or Town,	State, Z	(ip Code)
Z	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other then "natural, or items 23a or 28s-f ehow other traumatic event, the Medical Examiner must be rutified at		Barry E. Karlin/so			119 0	reen	moor	Irvi	ne,	CA 92	614			
ore,	es 1 a of Hei litem r othe		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ R	amoval from State	20b. Pla	ace of Dispo	sition (Na natory or	më of other place	9)	Apri	Ĭ 7,	200	. Location -	City or	Town, State
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Baltimore,	permit. Peges. Depertment of the important: if ite any injury or of once.		21. Signature of Funeral Service License	1111	MO12								P.0 larks		784 e, MD 21029
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	To the within 2 To the comple	Ž	29b. Signature and title of certifier				29	c. License	number			29d.	Date signe	d (Monti	h, Day, Year)
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12)	Jm		30. Name and address of person who call Chitra Rajagopal	ome feet cause of de	ath (Item	23a) (Type,	Print) Mill	Rd	Rockv	ille	, MD	2085	55		
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DHMH 17 Rev 1/2001

Sarah E, Kohlheim Baltimore, Maryland 21215-0036

			1 - For State Registrar		ryland / Dep	ertificate of	lealth and M	Mental Hyg	leg. No.	6 I	2617
2.5	Physici	an	Decedent's Name (First, Middle, La					2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic		Sarah	E.	Kohlhei		a Lacation of Dooth	April	4c. County	2006	6:23H M
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	Funeral Director		5. Social Security Number 6. S	Sex 7. Age	(In yrs. last birthday		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 01/30/1	Year)	9. Birthpla Count	ace (State or Foreign ry) Sylvania
	pu &		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I	ocation				10	Od. Inside City Limits
	within 72 hours after death with the Maryland ane. then "neturel", or items 23a or 28a-f ehow the Marical Examiran maritie notilised at	Director	MD Somers	et	Princes				10g. Citizen of V		1 ☐ Yes 2 No
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	death	Funerai	11. Marital Status	12 Was Doodoot F	ver in U.S. 13	. Was Decedent of H		pecify Yes or No-		e - America	
Maryland 21215-0036	ours after out, or Item	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	0	1 Yes 2 No		o Hican, etc.)	Specify	k, White, e Whit	
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ary	s 1 and 2 should be f Health and Mental item 27 is marked other traumatic eve	_	19a. Informant's Name/Relationship		19b. Ma	ling Address (Street	and Number or Ru	ral Route Numbe	r, City or Town,	State, Zip	Code)
	of Health item 27 i		Alice Fisher/Dau	ghter		Box 53, A	llen, MD				
ore	ges 1 t of H if iter or oth		20a. Method of Disposition Burial 2 Cremation 3	Removal from State		ematory or other pla	. 1	Date	20c. Location -		
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	To the To the comp	Σ	29b. Signature and title of certifier	10		29c. Licens	se number	i	29d. Date signed	d (Month, L	Jay, Year)
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			DL. USHA NA	completed cause of de	eath (Item 23a) (Typ	DIUSION	ST SAN	USBURU	40 >	80K	
46.6	Sta	ate	31. Date filed (Month, Day, Year)	32. Regis	r's Signature		-1 -1				
	Regist		APR 1 (2006	new It	food					

State of Maryland / Department of Health and Mental Hygiene | [] For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** APRIL 5, 2006 9:38 A SIGMUND LASKEY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SUBURBAN HOSPITAL BETHESDA MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
MARCH 22, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Year) Months Days Hours 1 □ XM 2 □ F Yrs. 91 Director 012-05-6135 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Director MARYLAND MONTGOMERY BETHESDA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8023 THORNLEY COURT 20817 23a U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ▼No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Specify. ģ 3 ☐ Widowed 4 X Divorced "natural", Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Mygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 **ENGINEER** EAGLE CAN COMPANY permit. Pages 1 and 2 should be filed w
Department of Health and Mental hygies
Important: If item 27 is marked other it
any injury or other traumatic event, its
once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) LOUIS LASOVICK SADIE LEBOVITCH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8023 THORNLEY COURT, BETHESDA, MARYLAND LOUISE S. SAMPSON/DAUGHTER 20817 20b. Place of Disposition (Name of PART 19X (Nematory or other place)
MENORAH GARDENS Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 04/07/2006 ROCKVILLE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Puneral Service Licensee 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of): Examiner CORONARY ARTERY DISEASE 15 YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit Exam and Due to (or as a consequence of) Box 68760, the attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ĕ Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Unknown nis certificate has been signed by I director, page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ AZOTEMIA / CHRONIC RENAL FAILURE 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HYPERCOAGULABILITY autopsy performed? 2 No 1 🗌 Yes 1 Yes 2 X No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1XYes 2 No 2X ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Injury 1 X Natural 5 Pending To the Hospital or Average within 24 hours after death.

To the Funeral Director: After the Funeral Director: After the Funeral filled in by the fur М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🖎 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check or one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier APRIL 6, 2006 ENRE, MO 10 21206 202-244-0060 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print) JEROLD M. ∕SHARE, M.D., 3301 NEW MEXICO AVE, NW, SUITE ##6, WASHINGTON, DC 20016 31. Date filed (Month, Day, Year) 32 negistrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

2006

			For State Registrar	State of i	Marylan		oartmen e <i>rtificat</i>			Mental H	ygien Rag. N	(UU)	ì	12619
		270	1. Decedent's Name (First, Middle,	Last)						2. Date of D		ay Ye	ar	3. Time of Death
to .	Physicia /Medic	-	Joseph M.	Lenn	on, Si	· .				April		2006		6:25 ^{a M}
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186					Age (In yrs.	last birthda			If Under 24 Hr	rs. 8. Date of E	lirth			
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	/land low		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or	Location						10	d. Inside City Limits
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	or 28	Directo	10e. Street and Number				10f. Zip				10g. C	itizen of Wha	t Count	ry?
	ath w	rai	11617 Deborah D			C 4	208		annia Origina	(Casaila Vas as I		USA 14. Race - A	marica	n Indian
336	be filed within 72 hours after death with the Maryland Ital Hygiene. d other than "natural", or itsms 23a or 28a-f show svent, the Modical Exardinal reveit be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decede Amed Force 1 (3x) es 2 If Yes, Give Year or Date	ss? □No 1941 –	42	If Yes, spec		Specify:	(Specify Yes or It erto Rican, etc.)	40-	Black, V Specify:W	Vhite, e	tc.
2-0	72 hou	sted	15. Decedent's (Specify only highest	Education		16a. Dec	cedent's Usua ve kind of wo	al Occupa	ation during most of w	rorking	16b.	Kind of Busine	ess/Indi	ustry
21215-0036	c * 19	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)		. <i>DO NOT u</i> . loyee		furing most of w		For	doral (~0110	ernment
2	filled v Hygie other 1	e Co	17. Father's Name (First, Middle, L.			ЕшБ	Toyee	кета		ame (First, Midd			30 V E	:IIIIIeIIC
an	id be ental ked o	To B	Michael Lennon						Eliza	beth Gar	nnon			
Maryland	nd 2 should be filled within the and Mental Hygiene. 27 is marked other then traumatic sysnt, the Market and the filled with the Market and the filled with the Market and the filled with the Market and the filled with the Market and the filled with the Market and the filled with the Market and the filled with the Market and the filled with the fill		19a. Informant's Name/Relationsh Mary E. Lennon/				•			Rural Route Num Potoma				Code)
altimore,	ages 1 ar		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		ate (cemetery, c	position (Nar	ther plac	1 12 -	Date ril 6, 2006		Location - City		vn, State
Baltin	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked sny injury or other traumatic snore.		21. Signature of Funeral Service L		Gat	2 = 1 = 1	eaven C Franci 500 Un	d Addres	s collyin	s Funera	al Ho	ome Ind	2	MD 20901
8	-4-8		23a. Part1.Enter the disease, or o shock, or heart failure. List of	omplications that cau	sed the deat									Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Metast		Recta	1 Card	inom	a					Onset and Death Years
on .	/Medical Examiner		resulting in death)	a	as a consec									
	Examine	_	Sequentially list conditions,	b. — Dissa to fort	as a soristic	userou de								
	nsit	mine	cause. Enter Underlying Cause (Disease or injury	200 10 (0)	ac a comoc	(001100 01).								
Ć.	execu an and rial-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a consec	quence of):							7	
68760,	ficate be executed physician and is the burial-transit	dical		d.									-	
	ertifica ding pl		IF FEMALE:	23c. If yes, outco	me of orego	ancv						004 0-1	a de litera	
P.O. Box	es that the death certificioned by the attending pool be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		n 2 ☐ Feta it at time of c	al death	3 □Ectopic p 5 □ Other (sp					23d. Date of Month		y Day Year
	uires that i signed by Id be deta	ρ	Part II. Other significant condition	ns contributing to deat	h but not res	sulting in the	underlying o	ause givi	en in Part I.	1				e cause of death?
Records,	Physician: The law requires that the death certif this certificate has been signed by the attending ral director, page 2 should be detached for use a	Completed								24a. Whau pe	topsy rformed?	prior deat	to com	sy findings available apletion of cause of
ita	ian:]	Be C	25. Was case referred to medical						26. Place of D	eath (Check onl				
Ž	Physician: r this certificatal director,	ToE	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 ☐ Inp	atient 2				4 🗀 Nursing	Home 5 🔀 Re			Specify)
o uc	ding P h. After ti funera		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investig		Injury Day Year)	28b. Time Injur	o of 2	28c. Injun Worl	/ at <br Yes 2 □ No	28d. Describ	e how in	jury occurred		
Division of Vital	or Attendate death	Certification:	2 Accident investig 3 Suicide 6 Could in 4 Homicide determi	ot be 28e. Place of	Injury - At h , etc. (Speci						(Street a		or Rural	Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funaral Director: After completely filled in by the funer	edical Co	29a. Certifier 1 🔀 Certifying (Check only one)	Physician: To the bi xaminer: On the bas and manne	is of examina	owledge, de ation and/or	eath occurred investigation	at the tin	ne, date and pla pinion, death oc	ice, and due to the	ne cause(e, date a	(s) and manne nd place, and	er as sta	ated. the cause(s)
	To the within To the	₩ W	29b. Signature and title of certifier	1			29		number		1	Date signed (A		
)	(2)		Nictor f	nigon				D23	308		Ap	ril 4,	200	06
	WII		30 Name and address of person victor Priego,	M.d 6420 I	of death (Ite	m 23a) (Typedge D	e, Print) rive,	Suit	e 4100,	Bethes	đa, I	MD 2081	L 7	
	Sta Regist		31. Date filed (Month, Day, Year)	6 2006 32.	istrar's Sign	ature	docute	j						

		1 - For State Registrar	State of Maryland	l / Depa <i>Cei</i>	artment of H	lealth and <i>Death</i>		iene 6006	12620
		1. Decedent's Name (First, Middle, Las-	")				2. Date of Death Month	h Day Year	3. Time of Death
Physi /Med		Theodore F. Lacho	wicz				April	5, 2006	10:03 AM
Exam		4a. Facility Name (If not institution, give			4b. City, Town, or	r Location of Deal	th	4c. County of Death	1
		Harford Memorial			Haure If Under 1 Year	de Grace	D D to at Birth	Harford	
Funera		5. Social Security Number 6. Se	7. Age (In yrs. la XM 2□ F		Months Days	Hours Min	. (Month, Day,	Year) 9. Birth	nplace (State or Foreign untry)
Directo	r	Usual Residence of Decedent	0	5			septembe	r 13, 1920	PA
yland		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
Mar.	ţċ	MD Cecil	R	ising	Sun				1∭XYes 2□No
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. sther then "natural", or Items 23a or 28a-f show ant, the Madical Examinar must be notified at	Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What Co	untry?
th wi	a	106 Reynolds Ave.			21911			USA	
tems	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?		Was Decedent of H f Yes, specify Cuba	lispanic Origin? (9 an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White	
36 s afte	by Fi	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	IXIYOS 2 NO		1 □ Yes 2 汉 No	Specify:		Specify: Who	ite
Hour It	8	15. Decedent's Ed	Year or Dates: WW II	16a. Dece	dent's Usual Occup	ation		16b. Kind of Business/l	
Maryland 21215-0036 nd 2 should be filed within 72 hours af lith and Mental Hygiene. 27 is marked other then "natural", or traumatic event, the Maddest Expur	Completed	(Specify only highest grad	de completed)	(Give	kind of work done DO NOT use retired	during most of wo	orking		,
212 d with diene.	E	Elementary/Secondary (0-12)	College (1-4or 5+)	Sto	itionary	Engineer		Chemical	
	BeC	17. Father's Name (First, Middle, Last)					me (First, Middle, N	Maiden Sumame)	
aryland should be t and Mental I	To E	Francis Lachowicz				Nora	(Unknown)		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-f show eny Injury or other traumatic event, the Modical Examinar must be notified.	(4)	19a. Informant's Name/Relationship (7		19b. Mailir	ng Address (Street	and Number or R	iural Route Number,	City or Town, State, Z	ip Code)
and and and and and and and and and and		Cecelia Lachowicz		P.O.	Box 393	, Rising	Sun, MD		
Baltimore, Dermit. Pages 1 ar Department of Hee mportant: If Item eny Injury or other		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 ★			sition (Name of matory or other place		6-2006	20c. Location - City or	
Pag ment ment tant:		4 Donation 5 Other (Specify	Arl	ingtor	. Nationa	l Cemete	ru A	rlington,	Virginia
Sall ermit separt mport ny in		21. Signature of Funeral Service Licen	see /	22	2. Name and Addre	ess of Facility R .	T. Foard	Funeral Ho	me, P.A.
m 6050	O	23a, Part1. Enter the disease, or comp	Googie					g Sun, MD	21911 Approximate
2 40		shock, or heart failure. List only	one se on each line.	. Do not ent	100	1	1	551,	Interval Between Onset and Death
Physicia	_	Immediate Cause (Final disease or condition resulting in death)	a Acute	M	YCordia	Infa	rction		
/Medica Examine	_		Due to (or as a consequ	ence of):	L				
-14	M 50	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	ence of):					
uted 1	듵	cause. Enter Underlying Cause (Disease or injury that initiated events	- 7	\sim					
), exect n and ial-tra	Examiner	resulting in death) Last	Due to (or as a consequ	ence of):					
8760, cate be executed ohysicien and the burial-transit	dical		· hyper	100	emia				
68 tiffical of physics the	Aedi	THE PERSON IS	111111						
Box eeth cert ettendin for use	an/A	230. Was decedent pregnant	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnancy	y		23d. Date of deli Month	
o deel he ett ed fo	<u>S</u>	in the past 12 months?	4☐ Pregnant at time of de	ath 5	Other (specify)			MOITH	Day Year
I Records, P.O. Box 68 The law requires that the deeth certific ate has been signed by the ettending p page 2 should be detached for use as	Physiclan/Med	9 Unknown Part II. Other significant conditions or		Minn in Abras	- 4	and in David I	22o Did tob	pacco use contribute to	the cause of death?
ds, ires the signed d be d	þ	Part II. Other significant conditions of	onthouting to death out not resu	iting in the u	ngerlying cause giv	ren in Fanti.		es 2 No 3 Pr	/
cord w requir been si	Completed						-		
Receiaw	dr.						24a. Was a autops perform	n 24b. Were au prior to death?	topsy findings available completion of cause of
Bal F E: The icate icate							1 ☐ Yes 2	2 2 No 1 □ Yes	2 12 No
Vit; vician certif recto	Be	25. Was case referred to medical examiner?	Hospital:	/	Ott	200	eath (Check only on		
Of Phys raths	<u>ا</u>	1 Yes 2 No 27. Manner of Death	i inpatient 2 € t	ER/Outpatier 28b. Time o	f 28c. Injui	ry at		ence 6 Other (Spec	ary)
On ding	‡ o	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Wo	rk?]Yes 2 □ No			
Division of Vital Records, to Attending Physician: The law requires: a slier death. Director: After this centificate has been signs in by the funeral director, page 2 should be	flea	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At ho	me, farm, st	reet, factory, office			reet and Number or Ru	ral Route Number,
Div el or A s after il Direction	Certification:	4 Homicide	building, etc. (Specify)			City or Town	1, State)	
Division of Vital Re To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page			ysician: To the best of my know						
he H in 24 he Fu plete	edical	one) 21 Medical Exam	iner: On the basis of examinat and manner stated.	ion and/or in					
To t	Σ	29b. Signature and attle of certifier	MAC		29c. Licens			9d. Date signed (Monti	
41	IA		MU		000	62903		54/05/06	
10		30. Name an solve s of son who	completed cause of death (Item	23а) (Туре,	Print)	N/N N	Caraca	MD 2107	18
10		31 Date filed (Month Day Your)	32 Banistrata Signat	O NON	AVE HO	UVICE	e lace !	7-1-10	. –
	State strar	31. Date filed (Month, Day, Year) APR 0 7 2006	32. Registrar's Signat	Spark					

Metz, Lewis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** PM Metz Apri 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Lions Manor Nursing Home Cumberland Allegany 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb 21, 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1**√** M 2□ F Months Days Hours Yrs. МĎ 213-12-9776 Director 85 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County itam 27 is markad othar than "natural", or Itams 23a or 28a-1 show othar traumatic evant, the Mcdical Examination was be mailfied at MD Allegany Cumberland 1√ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 937 Bishop Walsh Road Apt 5 21502 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: WWII/Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene. 1 Never Married Z Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 Assistant District Engineer MD State Hwy Adm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Louis Wesley Metz J. Pearl Chisholm Metz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Metz wife 937 Bishop Walsh Road Cumberland MD 21502 Department of Health Important: If itam 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/19/2006 Rocky Gap Veterans Cemetery Flintstone MD any injury once. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funeral Service License 108 Virginia Avenue: Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Dron my disease or condition resulting in death) cremos /Medical Du to (or as a consquence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, physician 90 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4☐Pregnant at time of death detached py signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 marketus 1 ☐ Yes 2 ☐ No 3 ☐ Probably page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \) 24a. Was an autopsy 2 No 1 ☐ Yes 2 No director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attanding Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 24 hours a Funarai 29a. Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 30. Name and address of person

Dr. Jesus H 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

trostburg, m

Broadway

o completed cause of de h (Item 23a) (Type, Print)

			= State Registra MEND#5, 10eper1			artment rtificate			and M		Reg. No.	UUU.	2622
	Physicia	an	1. Decedent's Name (First, Middle, Las	,	Ma		, 1			2. Date of De.	ath Day	Year	0 20 -
<	/Medic		Juseph Be	VNARD	11141	10-0C	Town or	Location of	of Death	1114	40	County of Dea	
7	Examin	er	4a. Facility Name (If not institution, give WASHINGTON ADVENTI				OMA F		Ji Dealii		40.	MONTGOME	
					(In yrs. last birthday) Il Under	1 Year	If Under		8. Date of Birt	th	9. Bi	rthplace (State or Foreig
н	Funeral Director			M 2□F	84 Yrs.	Months	Days	Hours	Min.	9/19/19	121 121	NEW	YORK
	2		Usual Residence of Decedent	1.	10c. City, Town or L	ocation							10d. Inside City Limits
	ehow	2	10a. State 10b. County MARYLAND MONTGOMER	i	SILVER SPR								1 □ Yes 2 No
:	28e-1	Director	10e. Street and Number			10f. Zip	Code				10g. Cit	izen of What C	country?
	within /2 nours atter death with the maryland ene. 906. 116. "About then "atter" or iteme 23e or 28e-f show the Medical Examinar must be nutified at the Medical Examinar must be nutified.	ਠੋ	205 THISTLE DRIVE				0901				US	SA	
	ne 23	Funeral	11. Marital Status	12. Was Decedent Ev	rer in U.S. 13.			spanic Ori	igin? (Spe	ecify Yes or No Rican, etc.)		14. Race - Am	
0	or ite	F	1 ☐ Never Married 2 🕅 Married	Armed Forces? 1 X Yes 2 □ No If Yes, Give		1 ☐ Yes 2		n, mexical Specify:		rican, etc.)		Black, Wh	
2	raii, c	Ď	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:									HITE
ה	natu Olical	etec	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Giv	edent's Usua e kind of wor DO NOT us	rk done d	during mos	t of work	ing	16b. K	ind of Busines	s/indusiry
21215-0036	Mithin Ine. Ihen '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	1	CHOLOGI		,			PUBI	IC HEALT	H SERVICE
N	be filed within 72 hours after death with the Marylan Hydiene. At Hydiene. Ad other then "natural; or iteme 23a or 28e-1 show event, the Medical Examinar must be notified at	မ င်	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name	e (First, Middle	, Maiden	Sumame)	
<u>a</u>	Mentel Merked o arked o	To B	HENRY MARGOLIN					SAI	RAH EI	NGELBERG			
Maryland	\$ 2 E E	-	19a. Informant's Name/Relationship (ype, Print)	19b. Mai	ling Address	(Street a	and Numb	er or Rura	al Route Numb	er, City o	or Town, State,	Zip Code)
	and 2 ealth a n 27 is		IRENE MARGOLIN - WIF	E	10201	GROSVE	NOR I	PLACE		215; ROCK			
ē,	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		20a. Method of Disposition 1 △ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Disp cemetery, cre	osition (Nan ematory or o	ne of ther plac			Dale	20c. L	ocation - City o	r Town, State
Ĕ	Pages ant: III		4 Donation 5 Other (Specify		JUDEAN MEM				3/26/2			EY, MD	
Baltimore,	permit. Deperti		21. Signature of Funeral Service Licer							NES-RINAL E; SILVER			
	& ∆ E ≥ a		23a. Part 1. Enter the disease, or com										Approximate
	Physician /Medical /Medical ivanial-iransit	I Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	consequence of):	i err/ m	-5° C	ma,		Tuide			
	ate b hysic the bi	lical	•	d									
О. Вох	at the death certificate by the attending phy tached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ 10 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	□Ectopic pr □ Other (sp		1				23d. Date of d Month	elivery Day Year
О.	w requires that been signed by should be deta	d by Pr	Part II. Other significant conditions of	ontributing to death but	t not resulting in the	underlying c	ause giv	en in Part	l.				to the cause of death? Probably 4 🗗 🗖 nknow
ပ္ထ	has by	mplete								24a. Was auto perfe 1 Yes	psy ormed?	death'	
酉	ician: Th certificate rector, pag	0	25. Was case referred to medical				· · · ·	26. Plac	e of Deat	h (Check only			
>	9 w =	To B	examiner? 1 2 res 2 No	Hospital: 1 Inpatien	t 2 ER/Outpati	ent 3200	ÓA Oth	er: 4 □ N	ursing Ho	ome 5□Res	idence	6 ☐Other (Sp	ecify)
0	ding Phys h. After this funeral di		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injury		28c. Injur Wor			28d. Describe	how inju	ry occurred	
Division of Vital	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	e 29a Place of Injur	ry - At home, farm, : (Specify)	M street, lactor		Yes 2□]No	28f. Location (City or To	(Street a.own, State	nd Number or . e)	Rural Route Number,
	pital c ours af erai Di filled ir		29a. Certifier 1 ☐ Certifying Pt	nysician: To the best of	f my knowledge, de	ath occurred	at the tir	me, date a	nd place.	and due to the	cause(s	and manner	as stated.
	24 hc 24 hc Fun etely	Medical	(Check only 2 Medical Examone)	niner: On the basis of e and manner state	examination and/or	investigation	n, in my o	pinion, de	ath occur	red at the time,	, date an	d place, and d	ue to the cause(s)
	o the	Me	29b. Signature and title of certifier	11/1	/			e number					nth, Day, Year)
	10		Ital h	Chi			45	20	3		4	1/04	12006
	(30. Name and address of person who			e, Print)						-	
			STEPHEN SMITH M.D.	WASHINGTON A				OMA PA	RK MD				
	St	ate	31. Date filed (Month, Day, Year)	32. Jegistrai	r's Signature	mede !	,						

DHMH 17 Rev 1/2001

			1 - State Registrar	1	Maryland / De		ent of Heate of De		_	giene 0	6 12623
,	Physic /Medi		Decedent's Name (First, Middle, La LOIS MARIE ME	•					2. Date of De. Month April	ath Day 2006	Year 7:05A M
	Exami		4a. Facility Name (If not institution, giv 1626 New Bride		or)			e City		4c. County o	of Death
	Funeral Director			ex 7 □ M 25 F	Age (In yrs. last birtho	Month		Under 24 Hrs Hours Min.		h y, Year)	9. Birthplace (State or Foreign Country) Delaware
	the Maryland 286-f show	ō	Usual Residence of Decedent		10c. City, Town o						10d. Inside City Limits
	with the M. 3a or 28e-f	Director	10e. Street and Number 1626 New Bridge		Pocomok	10f.	су Zip Code 1851	-		10g. Citizen of W	1 Yes 2 No
36	72 hours after death with the Maryland natural', or items 23a or 28e-f ehow disal Examinat must be coulded at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ▼ Divorced	12. Was Decede Armed Force 1 ☐ Yes 2 X If Yes, Give Year or Dates	s?]No	13. Was De If Yes, s	pedent of Hispa pecify Cuban, 1	anic Origin? (S Mexican, Puert	pecify Yes or No- o Rican, etc.)	Black	- American Indian, t, White, etc. White
21215-0036	S 29	Completed	(Specify only highest gra	lucation	16a. D.	ecedent's Us Give kind of fe. DO NOT .erk	sual Occupatio work done duri use retired)	n ng most of wor	rking	16b. Kind of Bus	siness/Industry
Maryland 2	should be filed with nd Mental Hygiene. marked other than imatic event, tha M	To Be Co	17. Father's Name (First, Middle, Last) Albert Edwin S				E	Ethel	Mae War	Maiden Sumame)
	s 1 and 2 should if Health and Mer item 27 is marks other traumatic		19a. Informant's Name/Relationship (1) Leona M. Hill/ 20a. Method of Disposition		19b. M 1 6 2 20b. Place of Di	6 Ne	√ Bric	Number or Rullinge Ro	ad, Poo	comoke	City MD
Baltimore,	Page nent o int: If iry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funer 1 ervice Licen)		crematory o ury (other place)	4/1			ury, MD
Ba	permit. Depertinimports eny lnjt		23a. Part1. Enter the disease, or comi	Dications that caus	ed the death. Do not	HOTTO	owav M	le I son	Funera Pocom	l Home	P.A. ty, MD 21851
	Physician /Medical		shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	a	EL SE	40	Nen) sease		Interval Between Onset and Death 5 months
	be executed icien and purial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	s a consequence of the same of	m si	re Ca rten	rlich y Di	y ogniti	2	Syers
68760,	ficate phys s the	edicai E		d	Hyper	tens	co				15 years
P.O. Box	wrequires that the death certi been signed by the attending should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		2 Fetal death	3 □Ectopic 5 □ Other (23d. Date Monti	of delivery h Day Year
	law requires that the as been signed by th 2 should be detache		Part II. Other significant conditions of		but not resulting in the		cause given in	Part I.	23e. Did to	1 -	ute to the cause of death?
Division of Vital Records,	62 CA	Completed by	Diabetes,	Type:					24a. Was a autops perform	y pried? dea	ere autopsy findings available or to completion of cause of ath?
Vita	ician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:		-	1 04		th (Check only on	W	
o	Phys this ral dii	<u>د</u>	1 Yes 2 No 27. Manner of leath	1 🗀 Inpai				1 ☐ Nursing H		nce 6 Other	
ision	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this cartificate ha completely filled in by the funeral director, page	Certification:	1	28a. Date of In (Month, D	ay Year) 28b. Time Injury - At home, farm,	у м		2 □No		w injury occurred	
Div	spital or ours after ours after ours after ours filled in b		4 Homicide determined 29a. Certifier Certifying Physics	building, e	t of my knowledge, de			late and place	City or Town	n, State)	or Rural Route Number,
	o the Ho	Medical	(Check only 2 Medical Examone) 29b. Signature and title of certifier	iner: On the basis and manner s	ot examination and/or	investigatio	n, in my opinio	n, death occur	red at the time, d	ate and place, and	d due to the cause(s) Month, Day, Year)
	0 42 4		30 Name and address of assess	wo	double (line 02)				1		5-06 201957-2112
٤	3		30. Name and address of person who can be seen and address of person who can be seen as a seen and address of person who can be seen as a seen and address of person who can be seen as a	7, Su	A 105	DB, Pripti	comok	+, M	0 218	5/	1101957-2112
	Sta Registr		APR 1 0 2	106 32. 1918	trar's Signature	And H					

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	Physicia	an	1. Decedent's Name (First, Middle, Last						Mont		ay Year	38 30p
	/Medic	al	Robert All 4a. Facility Name (If not institution, give			4	b. City, Town, or	Location of	Marc Death		2006 tc. County of Deat	8:3/p+ ™
	Examin	er	Peninsula Region		Center	1	Salis				Wicomico)
Ī	Funeral Director		717-07-0417	x 7. Age (li Xx M 2 ☐ F	n yrs. last bir 82		f Under 1 Year Sonths Days	If Under 24 Hours	Min. Apri	of Birth th, Day Yea 1 23,	1923 Sin	hplace (State or Foreign untry) ANSAS
	land ow		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Tow	n or Locat	ion					10d. Inside City Limits
	a-f eh	ctor	Maryland Carolin	e	Der	nton				,		1 ☐ Yes 2 XNo
	h with the	ai Director	10e. Street and Number 902 South Second	Street			10f. Zip Code 21629			Un:	Citizen of What Co Lted Stat America	ces of
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. In a marked other than "raturel", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinar mast te notified at Appe.	by Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Eve Armed Forces? 1 XYes 2 ☐ No If Yes, Give	1940-	If Y	s Decedent of Hi es, specify Cuba Yes 2 XNo	spanic Origin, Mexican, Specify:	in? (Specify Yes Puerto Rican, et	or No- c.)	14. Race - Ame Black, Whit	
Ś	2 hours	ed b	3 Widowed 4 Divorced 15. Decedent's Edi		1961 16a.	. Deceden	t's Usual Occupa	ation		16b.	Kind of Business	
61713	t within 72 iene. Then "ns	Completed	(Specify only highest grade Elementary/Secondary (0-12) 12 HS Grad	College (1-4or 5+)	Ge		d of work done of NOT use retired 1 Manage		of working	C	Lothing (Company
	id be filed lental Hyg ked othe ic event,	To Be C	17. Father's Name (First, Middle, Last) Albert Ross Mean	ıs					s Name (First, A garet Le			
Mary	and 2 shou ealth and M n 27 ie mar	_	19a. Informant's Name/Relationship (7 Anita Jane Means		19t 9(. Mailing /	Address (Street a	and Number ond St	or Rural Route creet, D	Number, City enton	y or Town, State, 2 , Marylar	Zip Code) nd 21629
בו בו בו	Pages 1 and the point of Healing int: if item ary or other		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State		ry, cremat	on (Name of ory or other plac metery	e) 4	Date +-2-2006		Location - City or oncord, A	
Dallino	permit. Departm importa any inju		21. Signature of Funeral Service Licens Randolph P.		er DVR						al Home, on, Mary	P.A. Land 21629
ı			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the	e death. Do	not enter f	he mode of dyin	g, such as ca	ardiac or respira	tory arrest,		Approximate Interval Between Onset and Death
, I	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Due to (or as a c			juries					
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	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c								
0000	cate be executed physician and the burial-transit	dicai Ex	resulting in death) Last	Due to (or as a c	onsequence	of):						
ם אסם .	death certifi e ettending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 [4 □ Pregnant at tim 9 □ Unknown	Fetal death		etopic pregnancy ther (specify)				23d. Date of de Month	livery Day Year
ords, r.	uires thet l signed by ld be dete	by	Part II. Other significant conditions of	ontributing to death but r	not resulting i	n the unde	artying cause giv	en in Part I.	23e	. Did tobacc		o the cause of death?
l Reco	To the Hospitel or Attending Physician: The law requires that the within 24 hours after death. To the Funerel Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be deteched.	Completed							-	. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
	ician: sertifica ector,	Be	25. Was case referred to medical examiner?	Hospital:	3.7		2□ DOA Oth	0.5	of Death (Check			
5	g Phys er this eral dir	n: To	1 X Yes 2 No 27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury (Month, Day Y	2 🗷 ER/O:	utpatient Time of Injury	3∐ DOA 28c. Injun Worl	4 🗆 (40)	28d Des	cribe how in	6 Other (Speniury occurred	
DIVISION	eath. or: Atte	catio	1 ☐ Natural 5 ☐ Pending 2 ⚠ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	3-28-	06 200)1 hr	SM. 10	Yes 2 🛣 N	o t	ralle	auto/tra r impact	
<u> </u>	ei or Ati s after d ei Direct	Certification;	4 Homicide determined	28e. Place of Injury building, etc. (- At home, fa (Specify)	arm, stree	, factory, office		MD R	or Town, St - 404	and Dumber of Si ate)Deep Si , Caroli	nore Rd. & ne Co., MD
	Mospit	ledicai (29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of entire to the basis of entire and manner state	kamination ar	e, death o	ccurred at the tin stigation, in my o	ne, date and pinion, death	place, and due h occurred at the	to the cause time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	11 1			29c. Licens				Date signed (Mon	
			Yande-Tour	nall, mo	th /ltcm 20:	(Tues F	OCM.	压 ———		M	arch 31,	2006
	20		1) T - 1 (completed cause of dea (AII, M)	ui (iiem 23a)	(Type, Pr	111 Pen	n Stre	eet, Bal	timor	e, Maryla	and 21201
*	Sta Registi		31. Date filed (Month, Day, Year) APR 2 0 2006	32. Registrar's	Signature	وع						

DHMH 17 Rev 1/2001

			For Stata Registrar	State of Ma		artment of F			iene) () (5 1	262	25
			Decedent's Name (First, Middle, Last	st)				2. Date of Dea Month	th	Vana	3. Time o	f Death
	Physici /Medic		Leroy	Moses				April	1,	Year 2006	6:47	P.M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Death		4c. County	of Death		
			7815 Heritage Far				nery Villa If Under 24 Hrs.		Mont	·	J	
ı.	Funeral Director		5. Social Security Number 6. S	ex 7. Age ☐M 2☐F	(In yrs. last birthday)	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day	, Year)	Coun		or Foreign
			228-36-7220 Usual Residence of Decedent	Λ	74 115.		L	Jan. 2	, 1932	New	York_	
	ylanc		10a. State 10b. County		10c. City, Town or L	ocation				10	od. Inside C	
	B Marita	ctor	Maryland Montgom	nery	Montgom	ery Villa	.ge				1 Yes	2 🗌 No
	ith th	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of V	Vhat Coun	try?	
	s 23a	rai	7815 Heritage Far			2088			U.S.			
	ltam:	Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married	12. Was Decedent Ev Armed Forces?	verin U.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	ecity Yes or No- Rican, etc.)		e - Americ k, White, e		
336	ali, or	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	Airforce	1 ☐ Yes 2 🔀 No	Specify:		Specify	: Wh	ite	
Ģ	be filed within 72 hours after death with the Maryland tal Plygiene. d other than "satural", or Itams 23a or 28a-f show d other than "satural", or Itams 23a or 28a-f show avant, the Madical Exardinar matter notified at	Completed	15. Decedent's Ec (Specify only highest gra	lucation	16a, Dece	dent's Usual Occup	pation during most of work	ina	16b. Kind of Bu	siness/Ind	ustry	
2	ithin 7	npie	Elementary/Secondary (0-12)	College (1-4or 5+	life	DO NOT use retire	d) most of work	mg .				
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and	l be fil ntal H ad otl	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam			Θ)		
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hyglene is marked other then "natural", or liams 23a or 28a-f show is marked other than "natural", or liams 23a or 28a-f show aumatic evant, the Maryleal Examiner is an bandified at	2	William Moses 19a. Informant's Name/Relationship (Type Print)	19h Maili	na Address (Street	Dorothy and Number or Rur		-	State Zin	Codel	
<u>8</u>	and 2 sealth an n 27 is		Elaine B. Moses -				Farm Dr.				,	86
ē,	f Healitam		20a. Method of Disposition	-	20b. Place of Dispo		<u> </u>		20c. Location ·			
Ê	Pages nent of int: If it		1XXsurial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify		1	em. Garde		:006	Olney, 1	Mary1	and	
saltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If itam 27 is marked any injury or other traumatic enone.		21. Signature of Funeral Service Licer	/ 1-	E	Warrand Addre	ss of Facility EI Funera	1 Direct	tion, I	ac.		
m	90 E 9 9		Vonald S.	Hottles			ille Pike			aryla		0852
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused to one cause on each line	he geath. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory arr	est,		Approximat Interval Bet Onset and	ween
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į.	Examiner			Due to (or as a	consequence of):							
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9	death certific attending pl	Ψ	IF FEMALE:	22a Huga automa a								
Box	attenc for us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	Fetal death 3	Ectopic pregnancy Other (specify)	y		23d. Dat Mor	e of delive. nth	-	Year
o.	at the de by the a tached	ysic	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown	ine or death 50							
۵.	The law requires that the death certificate has been signed by the attending sage 2 should be detached for use as	by Physician/M	Part II. Other significant conditions of	ontributing to death but	not resulting in the t	inderlying cause giv	en in Part I.	23e. Did tol	oacco use contr	ibute to th	a cause of c	leath?
rds	w requires been sig should be							1 □ Ye	s and No	3 ☐ Proba	ably 4 ⊟t	Jaknown
Records,	aw re	Completed						24a. Was a	n 24b. V	Vere autop	sy findings	available
	The lav	mo						autops perform	ned? d	eath?	npletion of c 2□ No	ause or
Vital	sician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?				26. Place of Deat					
	Physic this ce al dire	은	1 ☐ Yes 2 X No	Hospital:		IL SEL DON		me 5X Reside)	
Division of	ding P h. After I funera	ion	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	Wor	yat rk? Yes 2 ∐No	28d. Describe ho	w injury occurr	bd		
<u>s</u>	death ctor: / the	licat	2 Accident investigation 3 Suicide 6 Could not be		y - At home, farm, st			28f. Location (Si	reet and Numbi	ar or Bural	Route Num	pher
<u>></u>	spital or Al ours after o taral Dirac filled in by	Certification:	4 Homicide determined	building, etc.	(Specify)	,		City or Town				
	ospita hours unara uy fille		29a. Certifier 1 Certifying Ph	ysician: To the best of on the basis of e	my knowledge, deat	h occurred at the tir	me, date and place,	and due to the ca	ause(s) and ma	nner as sta	ated.	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filed in by the funeral director,	Medical	one)	and manner state	ed.	29c. Licens						,
1		-	29b. Signature and title of certifier					2	9d. Date signed			
•	10		30. Name and address of person who	completed cause of de-	ath (Item 22a) Mire-	D42	432		April 2	2, 20	00	
			DR. CHITRA DESIKA				: מת מווון	#327 OT	NEV MD	208	332	
	Sta	te	31. Date filed (Month, Day, Year)	32. egistrar	's Signature	and B	LULLI DI	JLI OL	لللثل و المنت	400	126	
	Registr		APR 062	2006	J. St. 19							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year **Physician** Baysil Atif Maghoub Mohamed-Ahmed 4 2006 4:26 /Medical 4c. County of Death
Montgomery 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 4 Hours 1⊠M 2□ F Yrs unavailable Maryland Director 3/31/06 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits onant: If item 27 is marked other than "natural", or itema 23a or 28a-f ahow Injuryor other traumatic avent, ite Medical Examinat must be notified at Rockville Montgomery 1 ☐ Yes 2X No Md Directo 10e. Street and Number 10f. Zin Code 10g, Citizen of What Country? 20853 U.S.A. 13701 Ashby Rd. deeth v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or item any injuryor other traumatic event, the Mental and once. Black, White, etc. 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: black 1 ☐ Yes 2 ☒ No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) none none 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Atif Maghoub Mohamed-Ahmed Cheryl Hunt 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co. 13701 Ashby Rd., Rockville, Md. 20853 Cheryl Mohamed-mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Maryland National 4/7/2006 Laurel, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Universal Mortuary 21. Signature of Funeral Service Licensee 411 Kennedy St., N.W. Wash. D.C. 20011 064 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ischemia /Medical Due to (or as a consequence of): **Examiner** Hemorrhage: pulmonary & cerebral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Extreme prematurity ed by the attending physicien and detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown certificate hes been signed by rector, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes 1 Yes To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifice filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Yes 2 XNo 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Tes 2 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier auco D0043490 4/3/2006 mes 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ernest L. Carter, MD 9017 Alton Parkway, Silver Spring, Md. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) **Physician** Mar 30, 2006 McElfish Adeline :45 am /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** St Vincent DePaul Nursing Home Frostburg Allegany If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Sep 21, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 ☐ XF 1920 ΜD 215-12**-**2265 85 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or itams 23a or 28a-f show traumatic avant, the Mcdical Examinational by notified at 1 ¥Yes 2 □ No Allegany MD Spring Gap Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 15100 Old Oldtown Road 21560 USA Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□Yes 2MNo Specify: white Baltimore, Maryland 21215-0036 Specify: ģ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. College (1-4or 5+) **Beauty Salon** owner/operator 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Grace Sellers Johnson Harry H. Johnson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 73 Spring Gap MD 21560 daughter Department of Health a Important: If itam 27 Is any injury or other tra <u>once.</u> Tisa Long 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State St. Luke's Cemetery 4/2/2006 MD Cumberland * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Dist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Advanced Dementia 6 menths disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) 4□Pregnant at time of death cate has been signed by page 2 should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy 2 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 4XNursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Yes 2 No 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 29c. License number worsochshir MO 000 55 325 March 30. 2006

State Registrar

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WONSOCK SHINMD

31. Date filed (Month, Day, Year) APR 0 3 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

48 Taron

2. Registrar's Signature

Terrace

Frostburg

State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day 4 William John Maslyn April 2006 10:47P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester Ocean City 1800 Baltimore Ave., If Under 1 Year If Under 24 Hrs.
Months Days Hours Min 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Feb. 22,1961 Birthplace (State or Foreign Country)
 NY **Funeral** 1⊠M 2□ F 45 Yrs. Director 062-64-0383 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Madical Examinar must be notified at Clifton Springs 1 ☐ Yes XXNo Director NY **Ontario** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14432 USA 1801 Pearl St. 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🛛 No Specify: þ 3 ☐ Widowed 4 K Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Farmer Dairy is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H lant: If Item 27 is marked ott Be Elmer Maslyn Barbara Langdon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1801 Pearl St., Clifton Springs, New York 14432 Barbara Maslyn (mother) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State permit. Page Depertment Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) 4-10-2006 | Clifton Springs, NY St. Agnes Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, Md. 21811 a. Part1. Enter the disease, or complications that caused the death. So not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart value. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** DIABETES SEVERAL YRS MELLITUS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I any locating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsectioned off-Examiner physicien and the burial-transit the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical use as t ettending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the e P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖼 Unknown CARDIAC COMPLICATIONS Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was autopsy performed? DIABETES 1 Yes Division of Vital within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Mote ۵ 1XYes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 TYes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ö To the Hospitel a within 24 hours aff To the Funerel DI Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 04-05-06 D 06241 cause of death (Item 23a) (Type, Print) 30. Name and address of person who comple 203 SNOW ST. SNOW HILL, MD. 21863 HOLZENORTH 31. Date filed (Month, Day, Year) 32. Degistrar's Signature State APR 0 6 2006 Registrar

DHMH 17 Rev 1/2001

			For State Registrar		State of M	larylan		artment <i>tificate</i>			and M	lental H	ygien Reg. N	. 00	6	26	29
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	Funeral Director		5. Social Security Number 201–42–4089	6. Sex	7. A	ge (In yrs. 54	last birthday) Yrs.	If Under 1 Months [Year Days	If Under Hours	24 Hrs. Min.	8. Date of 1 (Month, AUG 3	Birth Day, Yea 1, 1	951	9. Birthpi Coun PA	lace (State try)	or Foreign
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336	permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If Item 27 is marked other then "natural", or Items 23a or 28e-f show minportent: If Item 27 is marked other then "hadred Examinat must be notified at annual."	by Funeral Director	11. Marital Status	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decede If Yes, specifi 1 ☐ Yes 2			gin? (Spec , Puerto R	ify Yes or No ican, etc.)	•	14. Race - Ame Black, Whi Specify: Wh	
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Ma	nd 2 s lith an 27 is i		Mizael Oliveira							MD 21		r rown, State,	ZIP Code)
re,	of Heal		20a. Method of Disposition		20b. Place of Disp cemetery, cre	osition (Name	of of	1	Da			cation - City or	Town, State
imo	Pages ment of ent: If its ury or o		1 XBurial 2 □ Cremation 3 □ I '4 □ Donation 5 □ Other (Specify,		Eastern Bible C	Shor	e Can	'n	3/26	/06	Ga	lena,	MD
Baltimore,	permit Pages 1 and Department of Health Imporient: If item 27 any in ury or other tr	. 2	21. Signature of Funeral Service Licens 23a. Jan 1. Enter the disease, or comp		F	2. Name and ellow	Address S , F	or Facility Telf	enbe	in &	New:	nam Fu	neral Home
	Physician /Medical Examiner	1	Immediate Cause (Final disease or condition resulting in death)	a	the death. Do not erre. A consequence of): a consequence of):	かんかる	\	such as	cardiac or	respiratory a	rest,		Approximate Interval Between Onset and Death
68760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical Examiner	Exquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Merc		édos	1.5						243
O. Box	at the death certifics by the attending pt tached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	⊒Ectopic prec ⊒ Other (s <i>pe</i> c			_		2	3d. Date of de Month	livery Day Year
rds, P.	w requires tha been signed I should be det	by	Part II. Other significant conditions co		ut not resulting in the t	inderlying cau	ıse given	in Part I.		23e. Did to	_		o the cause of death?
of Vital Records,		Completed							_		an sy rmed? 2 \(\sqrt{No}	24b. Were au prior to death?	utopsy findings available completion of cause of
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital.						Check only o			
	Phys r this ral dir	1.70	1 Yes No	28a. Date of Injur				4 LI NUI	-	d. Describe h		Other (Spe	cify)
lon	th. : After is funera	tion	Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Injury	м	injury a Work? 1 ☐ Ye	s 2□N		a. Bootings (ow injury	occurred	
Division	el or Attending I s after death. il Director: After sd in by the funer	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubul	ury - At home, farm, st c. (Specify)	reet, factory,	office		28	f. Location (S City or Tox	itreet and m, State)	i Number or Ru	ural Route Number,
Ki	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	edical	29a. Certifier (Check only one) 1 ☐ Certifying Phy 2 ☐ Medical Exami	sician: To the best of ner: On the basis of and manner sta	of my knowledge, dea examination and/or in ted.	h occurred at vestigation, i	the time, n my opin	, date and nion, deat	d place, an h occurred	d due to the o	ause(s)	and manner as place, and due	stated. to the cause(s)
)	To the within 2 To the complete	M	29b. Signature and title of certifier	_ m		29c.	D5	177	35		29d. Date	30/D	h, Day, Year)
0	T .C	1	ame an ress of person who co	ompleted cause of d	eath (Item 23a) (Type	Print)	0.	GI.	- 1	1	^	- 10	
	Sta	to	31. Date filed (Month, Day, Year)	32. Registra	22 Chest ar's Signature	n Hill	KY	Ch	este	rtae	- 10	111) 0	420
	Registr	-0.0		0 2008	100 m		and .						
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u.	L		For Stete	State of N	Marylan		ertment of H		Mental Hy	20	106	12632
			Registrer 1. Decedent's Name (First, Middle, La	etl		061	uncale or i	Jeani	2. Date of De	Reg. No. U	100	3. Time of Death
	Physici	an		,					Month	Day	Yeer	
	/Medic		Darle 4a. Facility Name (If not institution, give			zabeth	4b. City, Town, or	lvie		30, 2	unty of Death	11:07 A M
	Examin	er			")		LaVale	cooation of De	atti		egany	
	Francis		1225 G National 5. Social Security Number 6.5		Age (In yrs. I	last birthday)	If Under 1 Year	If Under 24 H	rs. 8. Date of Bir	th		place (State or Foreign
	Funeral Director			I □ M 2 □ F	46	Yrs.	Months Days	Hours Mi		y, Year)	Cour	ntry)
			Usuel Residence of Decedent						1 02/ 00/	1900	nar)	land
	how		10a. State 10b. County		10c. City	y, Town or Lo	cation				1	Od. Inside City Limits
	e-fe	cto	MD All	egany			Rawling	gs				1 ☐ Yes 2 ☐ No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Coul	ntry?
	72 hours after death with the Maryland naturel', or lieme 23a or 28a-f show disal Examiner must be notified at	la	19830 Dawson	Cemetery	Road			21557		US	SA	
	r dea	Funeral	11. Marital Status	12. Was Deceder Armed Forces	s?	S. 13. \	Vas Decedent of H Yes, specify Cuba	ispanic Origin? In, Mexican, Pue	(Specify Yes or No erto Rican, etc.)		Race - Americ Black, White,	
36	or it	by F	1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give			☐ Yes 2 🗓 No	Specify:		Spi	ec <i>ify:</i>	
21215-0036	ture!	d b		Year or Dates	5 :	16a Danas	landa Harri Ossus	-4:		ACE Minds		White
7	c _ B	Completed	15. Decedent's E (Specify only highest gr	ade completed)		(Give	lent's Usual Occup kind of work done o DO NOT use retired	during most of w	vorking	16b, Kind o	of Business/In	dustry
12	filed within Hygiene. other then ent. the Mer	튽	Elementary/Secondary (0-12)	College (1-4o	r 5+)		r and Op			Pot	Groomia	n c
9	Hyg the	0	17. Father's Name (First, Middle, Last)		O WITC	.r ana op		lame (First, Middle			118
Maryland	V to D .	To B	Joseph	DeSales		Riley		Ursu	la	Cece1	ia Ma	artin
эŢ	s 1 and 2 should if Health and Men item 27 ie marke other treumatic		19a. Informant's Name/Relationship	Type, Print)		19b. Mailin	g Address (Street	and Number or	Rural Route Numb	er, City or To	wn, State, Zip	Code)
	1 and 2 Health a tem 27 is	1 8	David W. Ogilvie	/ husband		1983	0 Dawson	Cemete	ry Rd, Ra	awling	s, MD	21557
<u>ē</u>	s 1 a if Hei item othe	13	20a. Method of Disposition	_		lace of Dispo	sition (Name of natory or other place		Date		ion - City or To	own, State
Baltimore,	Pages nent of I int: if its ury or o		1. Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		(6)	-	*	1	04/03/200	6 F	lintsto	one. MD
alti	그 문문을 .	1	21. Signature of Funeral Service Lice	nsee					-			Home, P.A.
ä	Depa Impo eny is		Lilest (1	Many					et, Cumbe	_		1502
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caus	ed the death	n. Do not ente	er the mode of dyin	g, such as card	iac or respiratory a	rrest,		Approximate Interval Between
	Priysician		Immediate Cause (Final disease or condition	8	11	aine	V.					Onset and Death
4	/Medical		resulting in death)	Due to (or a	as a consequ		1					
	Examiner		Sequentially list conditions,	b			77-					
	D =	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a consequ	uence of):						
	ecute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
50,	sien s	<u> </u>	rosuling in obality case	Due to (or a	as a consequ	uence of):						
8760,	cate be executed physicien and the burial-transit	dicai		d								
9		0	IF FEMALE:	23c. If yes, outcom	an of oregon	nov						
Вох	death certifi e attending I id for use as	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant	2 Fetal	death 3	Ectopic pregnancy			23d.	Date of delive Month	ory Day Year
o.	at the de by the a tached	Physician/M	1 ☐ Yes 2 ☐ No 9 ☑ Unknown	9 Unknown		Balli 5	Other (specify)					
Δ.	that the ed by detail		Part II. Other significant conditions	contributing to death	but not resu	ulting in the ur	derlying cause give	en in Part I.	23e. Did t	obacco use o	contribute to t	ne cause of death?
Vital Records,	The law requires that ste has been signed b sege 2 should be deta	d by							10	Yes 2□X	o 3 🗆 Prob	pably 4 Unknown
Ö	w requir been si should I	Completed							24a. Was	an 2	4b Were auto	psy findings available
Re	The lay sete has pege 2	m d							auto	psy ormed?	prior to co death?	mpletion of cause of
g		Ö	25. Was case referred to medical					26 Place of D	leath (Check only	2 No	1 🖾 Yes	2□ No
5	Physicien: this certific at director,	0 8	examiner? 1½ Yes 2 □ No	Hospital: 1 ☐ Inpa	itient 2 🗆	ER/Outpatien	t 3 DOA Oth		Home 5 ☐ Resi		Other /Specif	w scene
of		ä	27. Manner of Death	28a. Date of Ir	njury	28b. Time of	28c. Injun	/ at	28d. Describe			y/ beene
<u>o</u>	Attending Indeath.	atio	1 □Natural 5 □ Pending 2 □ Accident investigation	n Found	106	Found	PM 1	Yes 2 No	Sub	uct	hang	edself
Division	or Attendation after deati	ii	3 Suicide 6 ☐ Could not to 4 ☐ Homicide determined	286. Place of		me, farm, str	eet, factory, office		28f. Location (Street and Ni	umber or Rura	I Route Number,
	tal or A s after al Dire ed in by	Certification:	T I I I I I I I I I I I I I I I I I I I			oomin	a facile	fy	Lava	le un	1356.	National they
	To the Hospital or I within 24 hours after To the Funeral Directon Disease Completely filled in D		29a. Certifier 1 Certifying P	hysicien: To the be miner: On the basis				ne, date and pla	ice, and due to the	cause(s) and	manner as s	tated.
	To the H within 24 To the F complete	Medicai	one)	and manner	stated.							
	To To	2	29b. Signature and title of certifier	0			29c. Licens	e number			gned (Month,	
	4		- Carcolta	ulan 1	V9		OCME			March	31, 20	006
	Sous		30. Name and address of person who	completed cause o	f death (Item	23a) (Type,		Street	, Baltim	ore M	arvil and	1 21201
		to	31. Date filed (Month, Day, Year)		# strar's Signa	ture 🙍		DITECT	, Darlin	ore, In	агутан	4 21201
	Sta Registr		APR 0 3 200		- 1	ture	W.					

			For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of F			iene) 06	12633
*	Physici	20	1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	h Day Year	3. Time of Death
100	Physici /Medic	al	Miguel An 4a. Facility Name (If not institution, give s		Portillo	4b Ciby Town o	r Location of Death	April	5, 2006 4c. County of Deatl	0022 M
*	Examin	ier	Montgomery Gen		spital	Olney			Montgo	
The state of the s	Funeral Director		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday,	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 8/21/		nplace (State or Foreign untry) Salvador
	pug *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Maryla -f sho fied at	to	Md Montgom			r Spring	3			1 ☐ Yes 2 X No
	with the	I Direc	10e. Street and Number 13527 Georgia A	venue A	pt.105	10f. Zip Code 2090	06	1	0g. Citizen of What Co El Sal	
36	72 hours after death with the Maryland natural; or Itema 23a or 28a-f show dical Examinat must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 XYes 2 □ No	an, Mexican, Puerto Specify:	Rican, etc.)	14. Race - Ame Black, White Specify:	
2-00	72 hou	ted	15. Decedent's Educ (Specify only highest grade	cation	16a. Dece	edent's Usual Occup	El Salva pation during most of work		16b. Kind of Business/	Industry
21215-0036	within and the man	Completed by	Elementary/Secondary (0-12)	Cotlege (1-4or 5-		d kind of work done DO NOT use retired dscappe]		9	Landscap	e Co.
Maryland	ould be filed Mental Hygid arked other atic event, u	To Be (17. Father's Name (First, Middle, Last) Miguel Angel				18. Mother's Nam Angeli	e (First, Middle, M .ca Por	,	-
	bra Em		19a. Informant's Name/Relationship (Type Maria Armida Sa			ing Address (Street 527 Geo			City or Town, State, Z t.105 Sil	ver Spring
Baltimore,	9°= 51		20a. Method of Disposition 1	emoyal from State	20b. Place of Disp cemetery, cre Cemete	osition (Name of omatory or other place of C	^{ce)} 4/12		20c. Location - City or	Town, State
Baltir	permit. Pag Department Important: any Injery once.		21. Signature Vifuneral Service Scense	in Da	San Mig	HILIP D	rss#f##ALD]	FUNER	AL SERVIC	
			23a. Part1. Enter the disease, or complishock, or heart fail re. List only on	cations that caused le cause on each line						Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Dilat	ed Co	ndiom	yopatl	M		Oriset and Death
	Examiner	Н		Due ty (or as a	consequence of	100/101	I'SUA	100		
-	p #	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):	(COVIO				
•	cate be executed physician and the burial-transit	Examine	cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):					
8760,	ysiciar e burii	dical								
9		Medi	IF FEMALE:	0- 11	4					
.O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify) _	у		23d. Date of deli Month	ivery Day Year
Δ.	s that the de ned by the a e detached t	by Ph	Part II. Other significant conditions cor	tributing to death bu	t not resulting in the	underlying cause giv	ven in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
rds	w requires been sign should be	ted b					·	1 □ Ye	es 2 Pro 3 □ Pro	obably 4 □Unknown
I Records,		Completed						24a. Was a autops perform	y prior to d	topsy findings available completion of cause of
of Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		_ 0#	ner.	th Check only on		
	Phys rthis raldii	7; To	1 ☐ Yes 2 D No 27. Manner of Death	28a. Date of Injur	28b. Time	III JU DOA	4 Nulsing H		ence 6 Other (Spec ow injury occurred	cify)
ion	Attending death. ctor: Afte y the fund	atio	2 Accident 5 Pending investigation	(Month, Day	Year) Injury		rk? Yes 2 □No			
Division	al or Attendes safter death	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ry - At home, farm, s . (Specify)	treet, factory, office		28f. Location (St City or Town	reet and Number or Ru n, State)	ral Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attention to the funetial of the funetial	Medical (29a. Certifier Check only one) 1 Certifying Physical Exemit	sician: To the best oner: On the basis of and manner star	examination and/or i	th occurred at the til nvestigation, in my o	me, date and place, opinion, death occur	and due to the carred at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. Licens	se number	2	9d. Date signed (Monti	h, Day, Year)
)	2		MANN	~		DO	06316	,9	4/2/0	b
			Matthew Mother	mpleted cause of de	18101 Pr	ince ph	Cop Dri	ve di	vey, MD	20832
	Sta Registi	ate rar	31. Date filed (Month, Day, Year) APR 0 7 2	32. Augistra	r's Signature	parte	V			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) March 21, Day 2006 Year Va 1ma н. Pettit **Physician** 3:45 А м /Medical 4a. Facility Name (If not institution, give street and number)
Charlotte's Home Assisted Living 4c. County of Death 4b. City, Town, or Location of Death Examiner Maugansville Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F 078-03-4228 Vrs June 6, 1914 NY Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2X No Funeral Director MD Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō or flems 23a 19603 Cool Hollow Road 21740 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 🏖 No Specify: Completed by 3 Widowed 4 ☐ Divorced White naturef 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/fndustry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 rmit. Pages 1 and 2 should be filed wipartment of Health and Mental Hygier portant: if flem 27 is marked other the yinjury or other traumatic event. Itsu ce. Secretary Private other i 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cora "Unknown" Earl Hillman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) Malcolm Pettit, JR - Son 57 Chadwock Drive Greencastle PA 17225 Baltimore. 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition National Crematory 1 Burial 2 XCremation 3 XPemoval from State 3/31/06 Falls Church VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22, Name and Address of Facility
Edward Sagel Funeral Direction 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, smock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Dementia Years Physician /Medical Due to (or as a consequence of): Examiner Malnutrition Months Sequentially fist conditions, if any, leading to intimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Physician: The law requires that the death certificate be executed iding physiclen and se as the burial-transit Ambulatory Disorder Months Due to (or as a consequence of): Records, P.O. Box 68760. Periphral Edema Completed by Physician/Medical JE FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 TNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2□ No 2 No 1 ☐ Yes Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 📉 No After this funeral of To the Hospital or Attending Pt. within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 To Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signatu nd title of certifier D0045031 April 6, 2006 completed dause d (nem 23a) (Type, Print) Leitersburg Pike Hagerstown MD 21742 19414 C Dr Siddiqui 31. Date filed (Month, Day, Year) State 2006 Registrar

	for State Ragistrar	State of Maryla		artment of H rtificate of I			giene Reg. No.	06	126	35
	1. Decedent's Name (First, Mid	dle, Last)				2. Date of Dea	ath Day	Year	3. Time of	Death
Physiciar /Medica		eth Penny				April			6:20	A M
Examine	A. Carrier Man and Man Advanced to	ion, give street and number)		4b. City, Town, or	Location of Dea	th	4c. Co	ounty of Death		
	12823 Holiday	Lane		Bowie			Pri	nce Geo	rge's	
Funeral	5. Social Security Number	6. Sex 7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Birt (Month, Da	h y, Year)	9. Birthp	lace (State o	or Foreign
Director	246-14-9447	TOW ZAF	84 Yrs.			(Month, Da) 07/25/	1921		Caro1	
and	Usual Residence of Decedent 10a. State 10b. Coun	ty 10c.	City, Town or Lo	cation				1	0d. Inside Ci	ity Limits
Manyl Faho	Maryland Prin	nce George's Bo	owie							2 No
28a-	10e. Street and Number	ice dedige 5 De	OWIC	10f. Zip Code			10a. Citize	n of What Coun	ntry?	-
Sa or	12823 Holiday	Iano		20716			USA		,	
uter death with the Ma in Items 23a or 28a-f s plinet must be notified	11. Marital Status	12. Was Decedent Ever in		Was Decedent of H	ispanic Origin? (S	Specify Yes or No-		Race - Americ		
or Ite	1 Never Married 2 Ma			f Yes, specify Cuba		to Rican, etc.)		Black, White,	etc.	
raf', o	3	od If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		S	wecify: Whit	e	
filed within 72 hours after death with the Maryland Hygiene. Whysiene. When then "natural", or Items 23a or 28a-f show ant, the Medical Examinat must be notified at Completed by European Director.	15. Deced	ent's Education lest grade completed)	(Give	dent's Usual Occupa	durina most of wo	orkina	16b. Kind	of Business/Ind	dustry	
ithin	Elementary/Secondary (0-12	College (1-4or 5+)	life. I	DO NOT use retired)	9		-		
led w lygier it, th		2	Home	Maker	40.14.4.4.1.11	(F) . A41.4 (Own :			
be find H H and H						me (First, Middle,		•		
y moutd			101 14 7	A.I.I. (0)		ne Laura				
d 2 sl h and 7 is r traur	19a. Informant's Name/Relation		1	ng Address <i>(Street a</i> Holiday				own, State, ZIP	C000)	
Healt Healt ther	Ben F. Wade/ S			•		Date TID		ion - City or To	wn State	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show endy joury or other traumatic avent, the Modical Examination and process. To Be Completed by Figures Director	1 ☐ Burial 2 🂢 Cremation	3 LINGHIOVALITOITI STATE	cemetery, crer	sition (Name of natory or other plac		07/2006		1	,	
Definition of permit Pages Department of mportant: If it in y injury or once.	4 □Donation 5 □ Other 21. Signature of Funeral Service		Huntt Cr			-		rf, MD	1 11	
Departing once	21. Signature of Furnal and	11		. Name and Addres					T HOME	3
	23a. Part1. Enter the disease.	or complications that caused the de						20/13	Approximat	.e
	shock, or heart failure. Li	st only one cause on each line.			3 ,	,			Interval Bet Onset and I	Death
Physician /Medical	disease or condition resulting in death)	a. Coronary A-	rtery Di	sease				5	Years	3
Examiner		Left Ventr		Ivnertroni	าง			5	Years	5
d	Sequentially list conditions if any, leading to immediate	b. Due to (or as a cons	sequence of):	урогогор.						
uted d ansit	cause. Enter Underlying Cause (Disease or injury that initiated events	Type II Dia	abetes					1	0 Year	rs
executed an and rial-transit	resulting in death) Last	Due to (or as a cons	sequence of):							
cate be executed physicien and the burial-transit	5	d Crypto eni	c Cirrho	sis				1	0 Year	rs .
nifica ng ph as th	S Lie service									
nat the death certification of the attending day the attending letached for use as physicilar/Medician	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pred 1 Live birth 2 F		Ectopic pregnancy			230	l. Date of delive	•	
ed fo	in the past 12 months?	4 ☐ Pregnant at time of		Other (specify)				Month	Day 1	Year
at the aby to stach	9 Unknown									
w requires that the death certiful been signed by the attending should be detached for use as leaded by Dhystolian/Med	Partii. Othar significant condi	tions contributing to death but not	resulting in the ui	nderlying cause give	en in Part I.			contribute to th		
een si						1	/es 2 □ l	10 3 Prob	ably 4 XIL	JUKUOMU
The law requireate has been s page 2 should						24a. Was autop	SV	4b. Were autop prior to cor	psy findings and pletion of ca	
The page							rmed? 2 X No	death?	2 □ No	
ician sertifi ector	examiner?					ath (Check only o	ne)			
physical this call direction of the call dir	Th.	Annual Contract of the Contrac	ER/Outpatien		4 Li Nursing i	Home 5X Resid			1)	
After funer	27. Manner of Death 1 XNatural 5 Pend		28b. Time of Injury	28c, Injury Work		28d. Describe h	now injury o	ccurred		
the the	2 Accident Invest 3 Suicide 6 Coul		theme form etc		Yes 2 □No	29f Location /6	Stroot and A	lumbos as Dura	I Clauta Alum	hor
ital or Attending P rs after death. el Director: After fed in by the funera	4 ☐ Hornicide dete	mined 28e. Place of Injury - A building, etc. (Spe	ecify)	eet, factory, office		28f. Location (S City or Tow	vn, State)	rumber or Hura	i Houte Num	Der,
pital ours a merel filled		ving Physician: To the best of my l	knowledge death	Occurred at the tim	a data and niac	a and due to the	221150(5) 25	d mannor as st	atod	
hs Hosp in 24 hou he Fune pletely fil	(Check only 2 Medic	al Examiner: On the basis of exam and manner stated.	ination and/or in	vestigation, in my of	pinion, death occ	urred at the time,	date and pl	ace, and due to	the cause(s	.)
To the Hospital or Attending Physician: The law requires that the death certification 24 hours atterdeath. To the Funerel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as Madrical Certification: To Be Commisted by Physician Medical Certification:	29b. Signature and Itle of certification			29c. License	number		29d. Date s	igned (Month, I	Day, Year)	
F S F O	1170	ne m		DI	10602	360	41	5/06		
	30. Name and address of person	on who completed cause of death (I	item 23a) (Type			Ψ		. ,	1979	
	Heidi E. Town			e Green C	rofton.	MD 21114				
State	24 D + (1) 1 (14 - 15 D - 14	ar) 32. Agistrar's Sig			,			-		
Registrar		6 2006	N. A.							

			1 - State of Maryland / Dep	ertment of Health and N ertificate of Death	, ,	ene 2006	12636
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici		James Walter Purdum, Jr.		Month April	Day Year 2006	3:05 P M
V	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	Cadimi		504 Buffalo Road	Mt. Airy		Carroll	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birth	nplace (State or Foreign
	Director		577-09-7510 1☑M 2□F 91 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day,) Oct. 31,	1914 Mar	yland
	<u> </u>		Usual Residence of Decedent				
	how		10a. State 10b. County 10c. City, Town or I	cation			10d. Inside City Limits
	89-1-0	cto	Maryland Carroll Mt.	Airy			1 ☑ Yes 2 ☐ No
	or 2	Director	10e. Street and Number	10f. Zip Code	104	g. Citizen of What Co	untry?
	23a		504 Buffalo Road	21771		United	States
	r dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
99	or it	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☑ No Specify:		Specify:	White
21215-0036	within 72 hours after death with the Maryland ene. Than "natural", or iteme 23a or 28e-f ehow La Medical Examiner must be motified at	d b	3 ☑ Widowed 4 □ Divorced Year or Dates:				
5-	net inet	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation te kind of work done during most of work DO NOT use retired)	ing 16	6b. Kind of Business/l	ndustry
12	than this	m	Elementary/Secondary (0-12) College (1-4or 5+)	echanic		City Tran	ai+
N	Hygie ther nt,		10 M		e (First, Middle, Ma		216
Maryland	12 should be filed within 'n and Mental Hygiene. 7 is marked other than "itraumetic event, the Mer	Be			Walters	,	
Z	hould d Me mark metic	T _o	James W. Purdum 19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Rur		City or Town State 7	in Code)
Σ	d 2 s th an 17 is traus			•		ryland 217	-
	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene 1 the Marylan Item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumetic event, I'm Medical Examinar must be notified at			position (Name of	Date 20	Oc. Location - City or	
Baltimore,	Pages nent of I ant: if its		123 Bunat 2 Cremation 3 Chemovarium State	Thr	il 8,	rnestown,	
Ξ	rtant rtant			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
Ba	permit. Pages 1 and 2 Department of Health a Important: if Item 27 is eny injury or other tra once.			E. Ridgeville Blv	auffer Fu d. Mt. A	ineral Hom Airy, Mary	es, P.A. land 21771
			23a. Part1. Enter the disease of complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition Respinator	ory tailure			Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of)	- y allan			
	Examiner		b ('0\0\)	ancer			Jurs
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):				1
	cate be executed physicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events c.			0.	
0	e exe ien a urial-l	EX	resulting in death) Last Due to (or as a consequence of):				
8760,	ate br nysica he bu	dicai	d				
	ng pt	Med	IF FEMALE:				
Вох	leath certific ettending p	an/	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	☐Ectopic pregnancy		23d. Date of deli	
Э.	dea he et ed fo	Physician/Me	O I Inknown	Other (specify)		Month	Day Year
P.0	at the by the	Phy	9 Onknown				
'n	The law requires that the death certifiate has been signed by the ettending page 2 should be detached for use as	b	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to	/
ğ	w requir been si should	ted			1 L Yes	2 □ No 3 □ Pro	obably 4 Onknown
Records,	lawr as be 2 sh	ple			24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
<u> </u>	ysician: The lavius certificate has director, page 2	Completed			performe	ed? death? ZNo 1 ☐ Yes	_
Vital	ertific ctor,	Be (25. Was case referred to medical examiner?	26. Place of Deat	h (Check only one))	
of V	Physician: this certificatal director,	2	1 Yes 25 No Hospital: 1 Inpatient 2 ER/Outpati	ent 3□ DOA Other: 4□ Nursing Ho	me 5 Residen	nce 6 Other (Spec	eify)
0	ng Pl		27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 1 ☐ Natural		28d. Describe how	v injury occurred	
<u>.</u>	endil path. pr: A he fu	atle	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Division	r Att	#	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town,	eet and Number or Ru State)	ral Route Number,
0	itel c irs afi rai Di led in	Certification:					
	To the Hospitel or Attending Phys within 2 hours alter death. To the Funeral Director: After this completely filled in by the funeral di	edical	29a. Certifier (Check only one) (Check o	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cau red at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
	o the o the omple	Med	29b. Signature and little of certifier	29c. License number	290	d. Date signed (Month	n, Day, Year)
	⊢≯⊢g		MANNE MID	DON 4/20	961	4/5/	7001
	\cap		1910///////////////////////////////////	Police N	10	1/2/6	006
١	U		30. Name and address of person who completed cause of death (Item 23a) (Type		va Maraila	' / and 21771	
			31. Date filed (Month, Per, Year) . 32. Refistrar's Signature	n Street Mt. Air	y, Maryla	anu 21//1	
	Sta Registi		APR 0 7 2006	1			

		Please T	ype or Prin Item 20 per State of Ma	t in Bland	ack Ind 54 4-20 / Depai	elible In Ob vit	k. Ensure A Health and N	II Copies . Mental Hvd	Are L	egible.	12637
	•	1 - For State Registrar	olato ol illa	, (f Death		eg. No.	300	12001
		1. Decedent's Name (First, Middle, Last,)					2. Date of Deat Month	th Day	Vaar	3. Time of Death
Physicia /Medic		Gertrude P. Palde	er					April	2°	2006	6:15 A M
Examin		4a. Facility Name (If not institution, give	street and number)	-		4b. City, Town	n, or Location of Death		4c. C	county of Death	
		Holy Cross Hospit	al al			Silver	Spring		Mo	ontgomer	y
Funeral		Social Security Number Social Security Number	7. Age	(In yrs. las	**	If Under 1 Ye		8. Date of Birth (Month, Day	Year)	9. Birth	place (State or Foreign
Director		579-18 - 3878	JW ZKAL	79	Yrs.			Sept. 23	19	26 New	York
and W		Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Loca	ation				······	IOd. Inside City Limits
fanyla (**ho	ō			•							1 ☐ Yes 2 🛣 No
28a-1	Director	Maryland Montgome	ery	211	ver Sp	10f. Zip Cod		1	On Citize	en of What Cou	atov?
ath with the Marylan 123a or 28s-f show			D . #/1	0				'			tuy:
e 23	Funeral	15115 Interlachen 11. Marital Status	Drive #41 12. Was Decedent I		13 W	2090		ecify Ves or No-		S.A. 4. Race - Americ	ean Indian
item item	Ę	1 Never Married 2 Married	Armed Forces?		lf.	Yes, specify C	of Hispanic Origin? (Sp Suban, Mexican, Puerto	Rican, etc.)		Black, White,	
rs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	••	11	ÜYəs 2∰i	No Specify:		5	Specify: Cat	ıcasian
within 72 hours after death with the Maryland ene. then "natural", or iteme 23a or 28s-f show he Madical Examiner must be notified at	Ped	15. Decedent's Edu	cation		16a. Decede	nt's Usual Oc	cupation		16b. Kind	d of Business/In	
in 72	Completed	(Specify only highest grad	e completed) College (1-4or 5	4)	(Give k. life. Di	ind of work do O NOT use re	ne during most of work tired)	ring			
d with	E	-12-	College (1-401 o		Homema	aker			Owr	n Home	
othe vent,	BeC	17. Father's Name (First, Middle, Last)					18. Mother's Nam	e (First, Middle, I	Maiden S	Sumame)	
Aenta Aenta Irked tice	To E	Stanley M. Karmaz:	Ĺn				Miriam	Tanzman			
short and N	1	19a. Informant's Name/Relationship (T)	rpe, Print)		19b. Mailing	Address (Str	et and Number or Rui	al Route Number	. City or	Town, State, Zip	Code)
alth alth		Sharon Rosenblatt	- Daughte	er	1917	Windmi	11 Lane Al	exandria.	a, VA	22307	
of He item	1	20a. Method of Disposition		20b. Plac	ce of Disposi	ition (Name of atory or other	place)	Date	20c. Loc	ation - City or To	own, State
Page hent c nt: if		1 ■ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		- 1			netery Apr.	3, 2006	5 Ac	lelphi,	Maryland
permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. important: if item 27 is marked other then "natural", or itema any injury or other traumatic event, the Medical Examiner manance.		21. Signature of Funeral Service Licens	00	,				effersor			
Depariment Department on its process.		Kobut S. E	rev			5755 Ca	stlewellan	Dr. Ale	xanc	lria, VA	22315
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ications that caused	the death.	Do not enter	r the mode of	dying, such as cardiac	or respiratory arr	est,		Approximate Interval Between
Physician	8 07	Immediate Cause (Final	Convest		loart 1	Failure				-	Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as			rallule					
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	je.	Sequentially list conditions, in any, loading to immediate cause. Enter Underlying	Due to (or as	a norseque	neu of):						
tificate be executed ig physicien end as the burial-transit	Examin	Cause (Disease or injury that initiated events	Chronic	. Rena	ıl Fai	lure					
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death certificate be e ettending physicie d for use as the bu	led										
h cert endin	2	23b. was decedent pregnant	23c. If yes, outcome 1□Live birth			Ectopic pregna	Incv		23	d. Date of deliv	
death one etten	<u>S</u>	in the past 12 months? 1 ☐ Yes 2 ☒ No	4☐Pregnant at			Other (specify				Month	Day Year
at the de by the tached	Physician/Medica	9 🗆 Unknown	3CJ OHNIOWH		-				_		
res that igned t be det	by F	Part II. Other significant conditions co		ut not result	ing in the und	dertying cause	given in Part I.				he cause of death?
equire en sig	e G	Altered mental s	status					1 🗆 Ye	es 2.	No 3☐ Prot	oably 4 □Unknown
The law requires that the ste has been signed by th bage 2 should be detache	Completed	Anemia						24a. Was a		24b. Were auto	ppsy findings available impletion of cause of
The I	E							perfora	med?	death?	2⊠ No
	0	25. Was case referred to medical					26. Place of Dear				
× ~ 0	To B	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 🔀 Inpatie	nt 2 E	R/Outpatient	3 DOA	Other: 4 Nursing Ho	ome 5 🗆 Reside	ence 6	Other (Special	(v)
g Ph er th eer th		27. Manner of Death	28a. Date of Inju (Month, Da		8b. Time of Injury	28c. l	njury at Work?	28d. Describe ho			,,
Attending ir death. ector: Alter by the fune	atlo	1 △Natural 5 ☐ Pending 2 ☐ Accident investigation	(Monar, Bu	, , , , ,	mary		T☐Yes 2☐No				
or Attendir after death. I Director: Af d in by the fur	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inj	ury - At hom	e, farm, stre	et, factory, offi	се	28f. Location (Si City or Town		Number or Rura	al Route Number,
affe Dir d in	er		Sullaing, 80	o. (Opacity)				2, 0. 10#	., Jiaio)		
22 y2 es on	CI										
ospita hours unera ly fille		29a. Certifier 1 Certifying Phy	sician: To the best	of my knowl	edge, death	occurred at th	e time, date and place,	and due to the c	ause(s) a	ind manner as s	tated.
To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical C	29a. Certifier 1 ☑ Certifying Phy (Check only one) 2 ☐ Medical Exam	sician: To the best iner: On the basis of and manner sta	examinatio	ledge, death on and/or inve	occurred at the estigation, in m	e time, date and place, ny opinion, death occur	and due to the cred at the time, d	ause(s) a ate and p	ind manner as s place, and due to	tated. o the cause(s)

State Registrar

Irina Ruban 1500 Forest Glen Rd.

(Monta, Par Yar) 2006 32. Registrar's Signature 31. Date filed (Monta, Pay

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D63343

29d. Date signed (Month, Day, Year) April 3, 2006

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Ragistrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 5, 20**0**6 **Physician** 4:35A. M Pugh Inez Grace /Medical 4b. City, Town, or Location of Death Laurel 4c. County of Death 4a. Facility Name (If not institution, give street and number) Greater Laurel Health and Rehab Ctr. **Examiner** Prince George's Birthplace (State or Foreign Country) 5. Social Security Number 577-20-7304 7. Age (In yrs. last birthday) 87 Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 25, 1919 6. Sex **Funeral** Days Hours Min. 1□M 2XF Vîrginia Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State r then "natural", or itema 23a or 28a-f ehow the Medical Exprementant be notified at 1 XYes 2 □ No Prince George's College Park Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20740 United States 8425 57th Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: White Baltimore, Maryland 21215-0036 Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) own home Homemaker permit. Pages 1 end 2 should be filed wil Department of Health and Mental Hygien Important: If Item 27 ie marked other the eny injury or other treumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edith Rebecca Highlander Virgil Ashby Harrell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8425 57th Avenue College Park, Maryland 20740 William E. Pugh -husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Parklawn Memorial Park 4/8/2006 Rockville, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Urinary Tract Infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Hypertension that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 X No Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a id be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown should peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2 autopsy performed? Yes 2\(\infty\) No 2 No 1☐ Yes 1 🗌 Yes To the Hospital or Attending Physician: ours efter death.

lerel Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No Certification; To 3□ DOA 28a. Oate of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours e To the Funerel [HS Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number MD AHEUSING D42580 April 5, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parmjit S. Aujla, M.D. 5632 Annapolis Road, #13 Bladensburg, Maryland 20710 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 06 Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of	of Marylan				lealth a Death	and M		giene	06	12639
*	in the state of th	75	Decedent's Name (First, Middle, L.	ast)							2. Date of Dea Month		Year	3. Time of Death
	Physicia /Medic		Peter Joseph Pa	lazzo							April 3			12:15 A M
	Examin	_	4a. Facility Name (If not institution, g						r Location o	of Death			unty of Deat	
•	la se		Heritage Harbor					apol:		Od Live	(5::		Arun	
	Funeral Director		577-05-4327	Sex 1∭M 2□F	7. Age (In yrs. 95	last birthday) Yrs.	Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Day 06 / 17 / 1	910	9. Birt Co Ita	hplace (State or Foreign buntry) 1y
	ow III		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Many Hear	tor	Maryland Prince	Georges	Gle	nn Dal	e							M∑XYes 2 □ No
	h the	lrec	10e. Street and Number				10f. Zi	p Code			1	0g. Citizen	of What Co	ountry?
	th wil	a	12411 Sir Lancel	ot Drive	9			769			1	JSA		
0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Important: If time 27 is marked other then "natural", or items 21a or 28a-f show any injury or other traumatic event, I'te Medical Examiner must be notified a once.	Funeral Director	11. Marital Status 1 Never Married 2 Married	Armed F	2 📉 No		Was Dece f Yes, spe 1 ☐ Yes		lispanic Ori an, Mexicar Specity:		cify Yes or No- Rican, etc.)	1	Black, Whit	erican Indian, e, etc.
2	hours a tural, c	ed by	3 ₩ Widowed 4 Divorced 15. Decedent's	If Yes, G Year or I	Dates:								ecity: Wh of Business/	ite
2	in 72 in 72	olete	(Specify only highest g	rade completed,		16a. Deced (Give life.	kind of w	ork done	during mos d)	t of workii	ng	100. Killa c	7 000111002	modely
7	yiene.	Completed	Elementary/Secondary (0-12)	Cotlege	(1-4or 5+)	Mater	Uph	olst	er			Busin	ess 0	wner
2	al Hyg othe	BeC	17. Father's Name (First, Middle, La	st)					18. Mothe	er's Name	(First, Middle,	Maiden Sur	name)	
<u>x</u>	ould b Menta arked	To	Joseph Palazzo								Manocch			
2	12 short and 7 is m	1	19a. Informant's Name/Relationship		_		•				Annapo]			
บ์	1 and Healti em 27	H	Louise Halley/ 20a. Method of Disposition	Daugnte.	20b. F	Place of Dispo	sition (Na	me of			ate			Town, State
2	pages ent of nt: ff it ry or c	li	tXXBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		State		Lin	coln		04/07	7/2006 H	Brentw	ood.	MD
Dailino	rmit.	1	21. Signature of Funeral Service Lic	ensee			eter !. Name a							al Home
Ω	88888		1110	4							ad Bowie		20715	
		3	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	mplications that ly one cause on	each line.	h. Do not ent	of the mo	ide of dylr	ng, such as	cardiac o	r respiratory ari	est,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to	Cor as a consec	ulence of):	1	7				-		
	Examiner		Sequentially list conditions	b. ++	4 Den	tens	101)		<u> </u>				
	pe sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o as a consec	uence of):	1-	100	W	1)1	SO Or	~0		
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00/0	ficate be executed physiclen and is the burial-transit	cal		d /	Oute	2/6	2N	al	1	ull	the	1		
00	tificati ig phy as the	edi				- /			10					
Š	th certi tending or use a	an/N	IF FEMALE: 23b. Was decedent pregnant		utcome of pregnation]Ectopic	oregnancy	,			23d	Date of de	livery Day Year
	es thet the death certific igned by the attending F be detached for use as	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4∏Preg 9∏Unk	nant at time of c	death 5	Other (s	specify)					IVIOII(II	buy Tou.
ŗ	thet the		Part I/Dther significant conditions	codtributing to	death but not s	pulting in the u	nderlying	cause giv	en in Part I	١.	23e. Did to	bacco use	contribute to	the cause of death?
	w requires thet the been signed by th should be detache	d by	House	Hep	afill	· S -					1 D Y	es 2 🗆 N	lo 3⊟Pi	robably 4 nknown
ဝင္သ	≥ □ ∞	plete		11 /							24a. Was autop		4b. Were at	utopsy findings available completion of cause of
Ľ	The ate h page	Completed									perfor		death?	2 □ No
	Physician; r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				Ott			Check only or			
0	Phys rthis raldii	- T	1 Yes 2 No 27. Manner of D ath	11	Inpatient 2 of Injury	ER/Outpatier 28b. Time o	_	JOA	4 (20 14)		me 5 Resid			ocify)
0	Attending F r death. ector: After by the funer	atlon	1 Natural 5 Pending 2 Accident investigat	(Mo	nth, Day Year)	Injury	М	28c. Injui Wor 1 [rk? ∣Yes 2	No				
DIVISION	Pospital or Attandi 24 hours after death. Funeral Director: A etely filled in by the fo	Certification:	3 Suicide 6 Could no determine	ad 200. Flat	ce of Injury - At h ding, etc. (Speci	ome, farm, sti	reet, facto	ory, office			28f. Location (S City or Tow	itreet and N n, State)	umber or R	ura! Route Number,
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in b	edical		Physician: To the and ma										
	To the within 2 To the complet	Me	29b. Signature and tille of certifier	11:1		^	2	9c. Licens	se number	101	2	29d. Date s	igned (Mghi	th, Dey, Yar)
)			Middle	HOTE	1, M1	(),	l	100	286	08	5	41	5/	061
			30 Name and address of person	o completed car	use of death (Ite	m 23a) (Type.	Print)	Url	S(VP.	,541	TE32	6510	ver s	P. m. 2090.
188	Sta	ate !	31. Date filed (Month, Day, Year)	32	Registrar's Sign	ature			/			[]		
	Regist		APR 0.4.2	2006	har a	k A	and a							

			For State Registrar	State of I	Marylan	d / Depa <i>Cei</i>	artment of F rtificate of	lealth a	ind Mental I-	Reg. No.]6	12640
ľ	Physici		1. Decedent's Name (First, Middle, Last DOROTHY ELIZABET						2. Date of APRII		2006	3. Time of Death 8:31P M
	/Medio Examir	11.64	4a. Facility Name (If not institution, give FREDERICK MEMORI				4b. City, Town, o		f Death		inty of Death	
*4 *3) 5-	Funeral Director		216-54-7925	9x 7. □ M 2⊠F	Age (In yrs. i	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. (Month,	Birth Day, Year) 28, 1913	Cou	place (State or Foreign intry) yland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation					10d. Inside City Limits
	Mary	ţō	Maryland Frederic	·k		.	rederick					1 ☐ Yes 2 ☑ No
	r 28a	Director	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cou	intry?
	th wit	alD	9023 Hamburg Roa	ad				21702		Un	ited S	tates
36	2 should be filed within 72 hours after death with the Maryland and Menial Hygiene. Ie marked other then "natural", or Itame 23a or 28a-f ehow aumatic event, the Mucical Exemitive roual be nuffilled at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	s? No		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Oric an, Mexican Specify:	gin? (Specify Yes or , Puerto Rican, etc.)		Race - Ameri Black, White, ec <i>ify:</i> V	
21215-0036	2 hou	ted	15. Decedent's Ed	ucation			dent's Usual Occup		of working	16b. Kind o	of Business/Ir	ndustry
215	thin 7 9.	ple	(Specify only highest gra	de completed) College (1-4)	or 5+)	life.	kind of work done DO NOT use retired	auring most d)	or working			
	filed within Hygiene. other then "	Completed	7			Нот	nemaker				vn Home	e
Maryland	be fill	Be	17. Father's Name (First, Middle, Last)						r's Name (First, Midd		name)	
7	hould d Mer marke marke	2	Charles S. Myers			19h Mailir	a Address (Street		manda Mose r or Rural Route Nur		wn State 7	in Code)
Ma	d 2 s Ith an 27 le i traui		Shirley Ferguson		ter		Quartet		Frederic			
ē,	Heal Heal Hem		20a. Method of Disposition	i / Daugi			sition (Name of natory or other place		Date		on - City or T	
E O	Page ent of nt: If ry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifi		re.		al Luthe:		April 8,	Middle	town.	Maryland
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menia Important: If item 27 Ie marked eny injury or other traumatic es once.		21. Signature of Funeral Service Licer						Stauffer			
Ö	Depa Impo eny is		1 202	Juto		16	21 Oposs	umtowr	n Pike Fr	ederick	, Mary	land 21702
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final									Approximate Interval Between Onset and Death
湯	/Medical		disease or condition resulting in death)	a Due to (or	as a consequ	uence of):	Day		disea			pears
	Examiner		Cognestially list conditions	b								
82	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury		as a consequ	uence of):						
	ate be executed hysicien and the burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or	as a consequ	uence of):						
8760,	be ex icien burial	a E		500 10 (01	us a conseq.	denoe ory.						
687	5 0 "	ope		d								
P.O. Box (death cert e ettending d for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnan 9 □ Unknown	2 ☐ Feta t at time of d	Ideath 3[Ectopic pregnancy Other (specify)	/		23d.	Date of deliv Month	very Day Year
	res that I signed by be deta	by Ph	Part II. Other significant conditions of	_		_			Magazine Control of the Control of t	d tobacco use	contribute to	the cause of death?
rds	w require been sig should b	pa pa	Atrial from	enin,	pne	ans	na, 75	ther	11	Yes 2	o 3 Pro	bably 4 Unknown
Division of Vital Records,	The lar	Completed	Colitis, con	gestive	2 K	ears	na, 75	ne	24a. W au pe 1 ☐ Ye	rtopsy rformed?	4b. Were auto prior to co death? 1 \(\sum \) Yes	opsy findings available ompletion of cause of
/ita	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?						of Death (Check on	ly one)		
of \	Physician: this certifical	2	1 ☐ Yes Z No 27. Manner of Death	Hospital: 1 I Inp		ER/Outpatier		4 🗆 190	rsing Home 5 Re			rfy)
LO	Jing After fune	tlon	Natural 5 Pending	(Month,	Day Year)	Injury	Wor	yat rk? Yes 2∐1		e how injury oc	curred	
Divisi	deal ctor y the	Certification;	"2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	28e. Place of	Injury - At ho etc. (Specif	ome, farm, str y)	reet, factory, office		28f. Location	(Street and No Town, State)	ımber or Rur	ral Route Number,
	ie Hospital or / 24 hours after ie Funaral Dire letely filled in b	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the be niner: On the basi and manner	s of examina	wiedge, deat tion and/or in	h occurred at the till vestigation, in my o	me, date an opinion, deal	d place, and due to t th occurred at the tim	he cause(s) and le, date and pla	manner as s	stated. to the cause(s)
	To the within 2. To the Complete	Me	29b. Signature and title of certifier				29c. Licens			29d. Date sig		
				~			DL	F716	9	4-	-6-	2006
١	0,		30. Name and address of person who	completed cause of	of death (Item	123a) (Type,	Print) Mm21	716	G CHA	N-HIX	19 H	o, Mp
梅袋	Sta Regist		31. Date filed (Month, Pan Year)	2006 32. R. To	istrar's Signa	ature	Survey I					•

		4	For State Registrar	State of Mai	ryland / Depa <i>Cei</i>	artment of Heartificate of De	aith and Me eath	ental Hygie	Transfer of the Article	12641
er G	Dhysisi	#	1. Decedent's Name (First, Middle	, Last)				2. Date of Death Month	Day Year	3. Time of Death
1	Physici /Medic		JOAN		ICHARDSON			April 4	2006	22:12 M
P.	Examin	er	4a. Facility Name (If not institution		T.0.1	4b. City, Town, or Lo			4c. County of Death	
4		*	MONIGOMERY G 5. Social Security Number	ENERAL HOSPI	IAL (In yrs. last birthday)	OLNEY If Under 1 Year If	Under 24 Hrs.	8. Date of Birth	MONT GOME	
·美	Funeral Director		213 40 7494	1□M 2\ F 67		Months Days F	Hours Min.	(Month, Day, Yi March 31	.1939 MAR	place (State or Foreign Intry) YLAND
	pu ,		Usual Residence of Decedent							
	ehov ad at	7	MD. 10b. County	OMERY	10c. City, Town or Lo ASHT (10d. Inside City Limits 1 ☐ Yes 2 No
	the M	ecto	10e. Street and Number	IONERT	7,01110	10f. Zip Code		100	. Citizen of What Cou	
	with Sa or	io	1514 LOST CREE	K DRIVE		20861		,	INITED STA	*
	death	hera	11. Marital Status	12. Was Decedent Ev	ver in U.S. 13.	Was Decedent of Hispa	anic Origin? (Spec	ofy Yes or No-	14. Race - Amer	ican Indian,
98	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland archerof of Health and Mental Hyglene. Ordents: If Item 27 is marked other then "natural", or Items 23a or 28a-f ehow initing of pages of the translation of the initing of the continuation of the medical Examination of the collision of the continuation of the collision of the colli	by Funerai Director	1 Never Married 2 Marri	If Yes, Give		If Yes, specify Cuban, N 1 ☐ Yes 2 ☑ No S	мехісап, Риеπо н Specify:	lican, etc.)	Black, White	, etc. HITE
21215-0036	hours tural',		3 Widowed 4 Divorced	Year or Dates:	163 Dagg	dent's Usual Occupation		16	b. Kind of Business/I	
7	in 72 n "na	piete	(Specify only highes	t grade completed)	(Give	kind of work done duri DO NOT use retired)	ng most of working	9	D. KING OF BUSINESSY	ndustry
212	d with	Completed	Elementary/Secondary (0-12)	College (1-4or 5+		1EMAKER			OWN HOME	
bu	al Hyg l othe	Bec	17. Father's Name (First, Middle,	Last)		18	. Mother's Name	(First, Middle, Ma	iden Sumame)	
yla	ould by Ment	To I		RWOOD					HOBBS	
Maryland	id 2 st ith and 27 is n traun		19a. Informant's Name/Relationsh JOHN D. RICHARD			ng Address (Street and LOST CREE				
re,	s 1 an f Heal ltem 2		20a. Method of Disposition		20b. Place of Dispo			-	c. Location - City or 1	Town, State
E O	Page Hento		1 Baurial 2 □ Cremation 4 □ Donation 5 □ Other (S)		UNION CEN		4/08/	06 BU	RTONSVILL	E, MD.
Baltimore,	permit. Pag Department Importent: I any injury once.		21. Signature of Funeral Service	Licensee Barke	22	Name and Address of MURIEL H.				000
18			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused the	he death. Do not ent	P.O. BOX 5 fer the mode of dying, s	OUSE, LAY such as cardiac or	respiratory arrest	E, MD. ZU	Approximate Interval Between
46	Physician		Immediate Cause (Final disease or condition	LUNG	CANCER					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):					
ŧ	Examiner	_	Sequentially list conditions,	b	consequence of):					
	ted	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence on).					
Ť	ate be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last	C Due to (or as a	consequence of):					
8760,	cate be chysicia the bur			d						
9	ntifica ng ph as th	Jedi	IE EEMALE.							
O. Box	at the death certificate be executed by the ettending physician and tached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliment	very Day Year
a	requires that een signed b hould be deta	by Pt	Part II. Other significant condition	ons contributing to death but	not resulting in the u	nderlying cause given i	in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
rds	w require been sig should b							1 🗆 Yes	2 Ø No 3 □ Pro	bably 4 Unknown
of Vital Records,	aw as b	Completed						24a. Was an autopsy	24b. Were au	topsy findings available ompletion of cause of
æ	The law rate has be	Com						performe	d? death?	2 No
/ita	Physicien: this certific al director,	Be (25. Was case referred to medical examiner?			1 -	6. Place of Death	Check only one		
-t	Physi- this c	70	1 Yes 25 No	Hospital: 1 Inpatien					⇔ 6 □Other (Spec	uty)
	fter	tion	27. Manner of Death 1 Natural 5 □ Pendin 2 □ Accident investic		Year) 28b. Time o	Work?	2 No	8d. Describe how	injury occurred	
Division	or Attendate after death Director: A	fica	3 Suicide 6 Could	not be 28e. Place of Injur	ry - At home, farm, st				et and Number or Ru	ral Route Number,
Š	P H H	Certification:	4 Homicide determ	building, etc.	(Specify)			City or Town, S	State)	
	To the Hospitel or At within 24 hours after of To the Funeral Direction place is completely filled in by	edical C	29a. Certifier (Check only one) Certifying 2 Medical	g Physician: To the best of Examiner: On the basis of and manner state	examination and/or in	h occurred at the time, vestigation, in my opini	date and place, as ion, death occurre	nd due to the caus d at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
•	To th within	Me	29b. Signature and title of certifie	~ ~		29c. License no D 3563			Date signed (Month)	
	5		30. Name and address of pers n	who completed cruss of 4-	ath (Item 23a) (Turn		-			
			JOSEPH KAPLAN				OLNEY.	MD. 208	32	
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar	r's Signature	and a				
	Regist	ar	APR 06	2006	15 PM	well .				

DHMH 17 Rev 1/2001

		Ŀ	For State Registrar	State of Maryla		artment of H rtificate of L			ene	6	2642
	Physicia		1. Decedent's Name (First, Middle, Last) Helen Irene Rizer					2. Date of Death Month	Day 31	Year 2006	3. Time of Death 5:30P M
	/Medic Examin		4a. Facility Name (If not institution, give st.	reet and number)		4b. City, Town, or	Location of Death	1	4c. County		J• J0r
	50	Ш	Allegany County N	<u> </u>		Cumber If Under 1 Year	land If Under 24 Hrs.	10.7. (6:4)	Alle	egany	
	uneral irector		5. Social Security Number 6. Sex 1 4 - 05 - 7174	M 2KF 7. Age (In y)	rs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 2 - 17 - 19	Year)	9. Birthpli Count PA	ace (State or Foreign ry)
	rector		Usual Residence of Decedent					2-17-17	17		
arylar	works In In	٦c	MD 10b. County Allegany		City, Town or Lo OVVigani					10	ld. Inside City Limits 1 Yes 2 No
the M	28e-f	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of	What Count	try?
h with	36 or		12512 Suder Lane			21524				USA	
r deat	ems 2	Funerai	11. Marital Status	2. Was Decedent Ever in Armed Forces?		Was Decedent of H	ispanic Origin? (Sr n, Mexican, Puert	pecify Yes or No- Rican, etc.)		ce - America	
rs afte	ei', or items 23e or 28e-f show Ers cirer rust be nullied at	by Fu	1 ☐ Never Married 2 ☐ Married 3.★Widowed 4 ☐ Divorced	1 ∐Yes 2 1 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specia	ty: tulo	ite
2 hou	"neturel", olical Exa		15. Decedent's Educi	ation	16a. Dece	dent's Usual Occup- kind of work done of	ation	king	16b. Kind of E		
ithin 7		Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	i) most of won	King	Danle !	·	
iled w	d other then "netul		17. Father's Name (First, Middle, Last)		Secre	etary	18. Mother's Nam	ne (First, Middle, M	Banki taiden Sumai		
d be	ked o	To Be	Maurice Murray					iace Pfei		,	
2 should be filled within 72 hours after death with the Maryland and Mantal Hottlene	is marked other then eumetic event, It e M.	 	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir	ng Address (Street			0.0	, State, Zip	Code)
and	Importent: If item 27 is marked any injury or other treumetic ev		Sharon Chirgott/	Daughter 1304	PO Bo	567 Fu	nkstown.	MD 21734	20c. Location	City or To	Ctato
Pages 1	or of		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Re		cemetery, crer	inatory or other place	1		Lavale	•	mi, ciate
permit. P	injur		' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses			2. Name and Addres		, = 00	Lavace	C, IVID	
ă ĕd	a grand		* Kickenf C.	Celans	Ho	urvey H.	Zeigier I	uneral 11	ome Hy	ndman	PA 15545
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the decause on each line.	eath. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death
	sician ledical		Immediate Cause (Final disease or condition resulting in death)	-SOSIS						0) weeks
	aminer			Due to or as a cons	sequence of):	, late	Diag.	1:410104	· C		- Jupala
T.	=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due o (or as a cons	sequence of):	V VOI V		CMON	9		
ecuted	and -trans	Examiner	that initiated events c. resulting in death) Last	Due to (or as a cons	sequence of):						
S & B	physician and the burial-transit			Due to (or as a cons	sequence or).						
tifficate	g phys as the	ledical	0.								
of the	certificate has been signed by the attending prector, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F	etal death 3	⊒Ectopic pregnancy	ı		1	ate of deliver	ry Dav Year
he de	the all	ysici	1 Yes 2 No	4□Pregnant at time o 9□Unknown	of death 5	Other (specify)					,
that t	ned by detait	by Ph	Part II. Other significant conditions cont	ributing to death but not	resulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use con	tribute to the	e cause of death?
requires	en sign	ed b	Kecent non- 6	wave	Quit	MJ		1 □ Ye	s 2×SLNo	3 Proba	ably 4 Dunknown
law e	ias be e 2 sho	ompieted	hyperlipiden	úQ				24a. Was ar autopsy	/	prior to con	psy findings available appletion of cause of
The The	cate h	O						perform 1 ☐ Yes 2		death?	2□ No
VICION:	recto	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	□ EB/Outpatier	nt 3□ DOA Oth	0.0	th <i>(Check only one</i> ome 5 \square Reside	-	her (Snecify)
g Phy	After this funeral di	I	27. Manner of Death	28a. Date of Injury (Month, Day Year	28b. Time o		y at	28d. Describe ho			
endin	or: Afi	catio	1 ☑ Netural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(,,,		Yes 2 □ No				
l or Att	Direct Direct	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	it home, farm, sti ecify)	reet, factory, office		28f. Location (Str City or Town		iber or Hural	Houte Number,
DIVISION OF VICE INCOMES, F.O. DOX 00100, To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 34 hours after death.	within 54 mous arier to again. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	edical C		cian: To the best of my er: On the basis of exam and manner stated.							
To th	COMP	Me	29b. Signature and title of pertifier	W		29c. Licens	e number	29	d. Date signe	ed (Month, L	Day, Year)
	6		V. A- Kary	luan		DI	1750	1	pnl.	3,5	600
2	XS.			npleted cause of death (Comb	erland	MI	215	OZ	
	Sta		31. Date filed (Month, Day Year)	32 Aegistrar's Si		radi					

State of Maryland / Department of Health and Mental Hygiene 0 6 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) JOSEP1+ Month 053UM **Physician** KULLS 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | May 13, 5. Social Security Number 6. Sex 1 Sum 2 ☐ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Yrs. 91 Marylánd 578-01-1409 Director Usual Residence of Decedent with the Maryland 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itema 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Queen Annes Chester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? US 21619 1813 Harbor Drive death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours after d il Hygiene. other than "natural", or Item 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ 3 ▼ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Automotive permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If Itam 27 Is marked other It any injury or other traumatic event. Its once. 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unavailable unavailable 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ohmer W. Webb, Jr. - Son-in-law 1813 Harbor Drive, Chester, MD 21619 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Ft. Lincoln Cemetery 4-10-06 Brentwood, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Linensey 22. Name and Address of Facility M00053 3035 Old Washington Rd. POB 156, Waldorf, MD 20604-01 <u> Huntt Funeral Home</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONGESTIVE **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine signed by the attending physicien and d be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown been si should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificete has b lirector, page 2 s autopsy A FIBRIU

25. was case referred to medical examiner? performed? 1BRILLATIA 1 Yes 2 No 1 ☐ Yes 2 ☐ No : After this certifical funeral director, Be 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours efter de To the Funeral Directo completely filled in by th 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Contitying Physician: To the best of my knowledge, death occurred at the time, date and blace, and due to the cause(s) and making as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of dertifier DEFENSE HIGHWAY ANNAPOR MO 21401 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2644 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Yee **Physician** APRIL 0337 M AVID E:D 2006 homas /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner NICOMIES PENINSULA REGIONAL 5. Social Security Number 5A45644 CENTER MESICAL If Under 1 Year | If Under 4 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 65 Yrs. 1**X**M 2□F Months Days Hours Min 215.36-0531 Director March 28, 1941 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b Counts nt of Heelih and Menial Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f ehow or other traumatic event, it a Medical Examinating in painting at 1 Yes 2 No Miconico Funeral Director **JEN** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21822 4065 Koad Shroon filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 XYes 2 □ No 21215-0036 1 ☐ Yes 2 XNo Specify: Glac Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DELTER ontrol u Pon I 18. Mother's Name (First, Middle, Maiden, Sumame) Maryland 17. Father's Name (First, Middle, Last) s 1 and 2 should be fill I Heelth and Mental H tem 27 is marked oth dla eiD ဂ္ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Nama/Relationship (Type, Print) Wife 4065 Dishroon RD Eden LeiD 21822 BERHA 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 4 Donation 5 Other (Specify)

21. Signature of Euneral Service Licensee

Anthony E. Ward Funeral Home

23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Immediate Cause (Final) 1 Burial 2 Cremation 3 Removal from State Salisbury permit. Page Department of Important: if any injury or once. Anne, MD 21853 Approximate Interval Between Onset accordant Immediate Cause (Final disease or condition resulting in death) DV Physician 1 Church /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate has been signed by the attending physicien and rector, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 ☐ Ectopic pregnancy Month Dav Y*e*ar 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the upderlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 1 ☐ Yes of Vital After this certifical funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3 □ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Hospital or Attending 5 Pending investigation after death.

I Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funerel Directo completely filled in by ti 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TANTE (AW 1340 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

7 2006

			1 - For State Registrar	State of Marylan	-	artment of F tificate of		•	giene 006	12645
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day Year	3. Time of Death
	/Medic	ai	RUTH ELEANOR REED	reat and number		4h Cih. Tour	r Location of Deal	4	4c. County of De	1000 4
	Examin	er	4a. Facility Name (If not institution, give st Peninsule-Regional		br	00.	rum	111	IU CON	1
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year	If Under 24 Hrs		7 -	irthplace (State or Foreign Country)
	Director		197-28-1608	^{M 2}	Yrs.	Months Days	Hours Min	(Month, Da 11-03-		NSYLVANIA
	puq .		Usual Residence of Decedent 10a. State 10b. County	10c Cit	y, Town or Lo	cation				10d. Inside City Limits
	death with the Maryland me 23a or 28a-f ehow rmat be routfied at	ŏ	MD WICOMIC		•					1 Tes 2 No
	28a-	Funeral Director	10e. Street and Number	,0 P	ARSONS	10f. Zip Code			10g. Citizen of What	Λ
	3a or	Ö	7888 PARSONSBURG RO	ΔT)			349		USA	•
		ner		Was Decedent Ever in U Armed Forces?	.S. 13. \	Was Decedent of H f Yes, specify Cuba		Specify Yes or No		nencan Indian,
٥	ours after death with the Marylar rat', or Iteme 23a or 28a-f ehow Exerciper mout be notified at	/Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No		Tes, specify Cuba	Specify:	to Alcan, etc.)		WHITE
2-0036	72 hours after "natural", or ite	d by	3√ Widowed 4 Divorced	Year or Dates:						
ņ	22 8 3	Completed	15. Decedent's Educ (Specify only highest grade	completed)	16a. Deced (Give	lent's Usual Occup kind of work done OO NOT use retired	ation during most of wo d)	rking	16b. Kind of Busines	ss/Industry
7 7	within iane.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	ļ.	MEMAKER	,		OWN HO	ME.
פ	be filed tal Hygi d other event, I	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Surname)	
/Ian	D & 20	ToE	WALTER L. SEHMAN				ELIZABI	ETH EDNI	E	
Mar	d 2 shouth and M 7 is mar treumat		19a. Informant's Name/Relationship (Typ	•	1	•			er, City or Town, State	
e G	s 1 and f Health item 27 other ti		DONNA CLARK - NIECE 20a. Method of Disposition		-			ROAD, SA	LISBURY, MA 20c. Location - City	RYLAND 21804
	Pages nent of thint: If its iry or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	movai irom State		sition (Name of natory or other place	F			
alt	permit. Pages Department of I Important: If It any injury or o		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee			EMETERY Name and Addre			SALISBURY,	
ŭ	Dep mp		Allesso Ham	1 // //					NERAL HOME SBURY, MARY	
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the deat						Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition			REBRA				Onset and Death
	/Medical		resulting in death)	Due to (or as a conseq	uence of):					
	Examiner		Sequentially list conditions, b.	HYPER		102				10 YEARS
	led Isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury	Due to (or as a conseq	uence or):					
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08/PO	icate be executed physician and s the burial-transil	edicai	d.							
_		ledi	IF FEMALE:							
ŏ	eath certifi attending for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregnant1 ☐ Live birth 2 ☐ Feta	Ideath 3	Ectopic pregnancy	<i>(</i>		23d. Date of o	lelivery Day Year
	at the dea by the a tached fo	sic	1 Yes 2 No 9 Unknown	4☐Pregnant at time of d 9☐Unknown	leath 5	Other (specify)				22)
ŗ	± 20 €	/ Ph	Part II. Other significant conditions cont	ributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use contribute	to the cause of death?
ecords,	uires sign	d by	URINARY T	ract In	fect	100		101	Yes 2. 11√10 3.	Probably 4 Unknown
<u>o</u>	aw require s been si 2 should b	ojete	CARDIOMY	OPATH	1			24a. Was	an 24b. Were	autopsy findings available
Ľ	sician: The law certificate has b irector, paga 2 s	Completed	PNEMMONIA				=		ormed? prior to death' 2 No 1 Ye	
VITAII H	ian: prtifica ctor, p	BeC	25. Was case referred to medical examiner?				26. Place of De	ath Check only o		20,10
> 0	Physician: this certific ral director,	To	1 ☐ Yes 2 ☐ No	ospital: 1 Inpatient 2	ER/Outpatien			Home 5 ☐ Resid	dence 6 □Other (Sp	pecify)
	De je	:uo	27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor		28d. Describe I	now injury occurred	
DIVISION	Attending ir death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	ome farm str		Yes 2 □ No	28f Location /	Street and Number or	Rural Route Number
<u>≥</u>	after Direction by	Certification:	4 Homicide determined	building, etc. (Special	(y)	eet, ractory, ontoe		City or Tov		Total Trodio Transci,
	To the Hospitel or Attendir, within 24 hours after death. To the Funerel Director: Algompletely filled in by the fu		29a. Certifier 1 Certifying Physi	cian: To the best of my kno	owledge, death	occurred at the tir	me, date and plac	e, and due to the	cause(s) and manner	as stated.
	the Hi in 24 the Fu	Medicai	one)	er: On the basis of examina and manner stated.	tion and/or in					
	Tor	Σ	29b. Signature and title of certifier	Tal In	M.	29c. Licens	e number	62	29d. Date signed (Mo	nth, Day, Year)
	Dis.		/				7		TIPICIL	03,2006
	20°		30. Name and address of person who cor			Print) -A RE	GIONI	+L ME.	DICAL CE	03,2006 HTER. MD
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature					
	Registr		APD 0 5 200			4				

ORIGINAL

			St State Registrar	ate of Maryland /	Department of He Certificate of D		ntal Hygien Reg. N	211116	12646
	Physici		1. Decedent's Name (First, Middle, Last) Donothy P	Rodman			Date of Death Month Da	ay Year	3. Time of Death
)	/Medic Examin		49 Pacility Name (If not institution, give street		4b. City, Townsor I	lisbar	4		mico
	Funeral Director		5. Social Security Number 6. Sex 1 6. Sex 1	2⊠ F 7. Age (In yrs. last i	birthday) If Under 1 Year Months Days Yrs.	Hours Min.	Date of Birth (Month, Day, Year 0/31/1923	9. Birth Cou	nplace (State or Foreign untry) cyland
	ehow	ž	Usual Residence of Decedent 10a. State 10b. County		own or Location				10d. Inside City Limits X□ Yes 2 □ No
	ith the M or 28a-f	Directo	Maryland Worcester 10e. Street and Number		cean City 10f. Zip Code	10.40	10g. C	itizen of What Cou	
	death w	Funeral [13305 Constitutiona.	Vas Decedent Ever in U.S.	13. Was Decedent of His If Yes, specify Cuban	L842 panic Origin? (Specify	Yes or No-	USA 14. Race - Amer	
036	ours after ral', or Ite Exacting	by	1 Never Married 2 XMarried 1	nmed Forces? ☐ Yes 2 [X]No i Yes, Give 'ear or Dates:	1 ☐ Yes 2 🔀 No	Specify:	in, etc.)	Black, White	white
Maryland 21215-0036	buid be filed within 72 hours after death with the Maryland Merial Hygiene. arked other then "netural", or tems 23s or 28s-f show atte event, the Medical Exactinar must be notified at	Completed	15. Decedent's Education (Specify only highest grade con Elementary/Secondary (0-12)	npleted)	Sa. Decedent's Usual Occupat (Give kind of work done du life. DO NOT use retired) Homemaker	ion uring most of working		Kind of Business/I	ndustry
land 2	should be filed nd Mental Hygi marked other matic event, II	To Be Co	17. Father's Name (First, Middle, Last) Frank Romecki			18. Mother's Name (Fi		n Sumame)	1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1
Mar	nd 2 shealth and 27 is m		19a. Informant's Name/Relationship (Type, F Frank Rodman/husband	rint) 19 d	9b. Mailing Address (Street at 13305 Constit	nd Number or Rural Ro tutional Av	oute Number, City Ve., Ocean	or Town, State, Z.	ip Code) MD 21842
altimore,	Pages 1 and on the source of t		20a. Method of Disposition 1 □ Burial 2 ☐ Cremation 3 □ Remove 4 □ Donation 5 □ Other (Specify)	val from State ceme.	of Disposition (Name of tery, crematory or other place)	1		Location - City or 1 lisbury,	
Baltir	permit. Pages Department of Important: If I eny Injury or once.		21. Signature of Funeral Service Licenses	re- PTP	22. Name and Address Holloway F		e Profes	sional A	ssociation
	y.		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final	use on each line.	o not enter the mode of dying	, such as cardiac or re	spiratory arrest,		Approximate Interval Between Onset and Death
,	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a consequence		· - a			
		lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	31ENOS1	5 64-	<u>-C5</u>		
8760,	certificate be executed adding physicien and use as the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	se of):				
Õ	ertificate ding phys		IF FEMALE:	Even outcome of crampany					
O. Box		Physician/Me	in the past 12 months?	fyes, outcome of pregnancy □Live birth 2 □ Fetal dea I□ Pregnant at time of death □□ Unknown				23d. Date of delik Month	very Day Year
_	law requires that the death as been signed by the atter 2 should be detached for	þ	Part II. Other significant conditions contribu	ting to death but not resulting	g in the underlying cause giver	n in Part I.		use contribute to	the cause of death?
Vital Records,	0 5 0	Completed					24a. Was an autopsy performed? 1 ☐ Yes 2 K N	prior to o death?	topsy findings available completion of cause of
Vita	sician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	tal:	Other	26. Place of Death (Co	heck only one)		
Division of	Attending Physician: Ir death. ector: After this certific by the funeral director.	tlon: To	1 105 2 19-190	1 2 patient 2 EHV	b. Time of 28c. Injury Nork	4 Nursing Home	5 Residence Describe how inj		ify)
DIVIS	P aft or	Certification:	2 Suiside 6 Could not be	Be. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f.	Location (Street a City or Town, Sta	und Number or Rui te)	ral Route Number,
	To the Hospitel within 24 hours a To the Funerel completely filled	edical C	(Check only /2 Medical Examiner:	n: To the best of my knowled On the basis of examination and manner stated.	ige, death occurred at the time and/or investigation, in my opi	e, date and place, and nion, death occurred a	due to the cause(it the time, date ar	s) and manner as nd place, and due	stated. to the cause(s)
	To th withir To th comp	M	29b. Signature and title of certifier		29c. License			ate signed (Month	
,	E.		30. Name and address of person who complete	ated cause of death (Item 23)	a) (Type, Print)	15 84/0		4/2/	106 y mo 2189
	Sta	te.	GI-HUM WAR 31. Date filed (Month, Day, Year)	32. Registrar's Signature	Amrowu	1800 CT.	SAU	soun	y mo 2189
	Registr		APR 0 6 2006	Down &	Sparte				

			For State Registrar	State	of Marylan	•	artment of tificate of		nd Mer		ne 0	6	12647
			Decedent's Name (First, Middle, Last	st)					2.	Date of Death		V	3. Time of Death
	Physicia /Medic		Pascual	Songco					1	Month April 3	Day , 2006	Year 5	12:03 P M
	Examin		4a. Facility Name (If not institution, give	street and no	umber)		4b. City, Town,	or Location of	Death		4c. Count	y of Death	
			21909 Ruby Drive				Boyds				Monto	jomer	У
	Funeral		5. Social Security Number 6. S 577-52-4474	ex Min 2□F	7. Age (In yrs. 96	last birthday) Yrs.	If Under 1 Yea Months Day		Min.	Date of Birth (Month, Day, Y		Cou	place (State or Foreign intry)
	Director		Usual Residence of Decedent		90	115.			Ma	ay 17,	1909	Phi	lippines
	land w H		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	Mary	tor	Maryland Montgon	nery		Boyds	3						1 ☐ Yes 2X☐ No
	th the	Director	10e. Street and Number				10f. Zip Code			10g	. Citizen of	What Cou	intry?
	23a c		21909 Ruby Drive				208	41				USA	
	teme	Funeral	11. Marital Status	Armed F		.S. 13. \	Was Decedent of f Yes, specify Cu	Hispanic Origir ban, Mexican, I	in? (Specify Puerto Ric	y Yes or No- an, etc.)		ce - Amen ack, White	can Indian, , etc.
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	If Yes G	2□No live Dates:1926-	-32	1 ☐ Yes 2 🔀 N	Specify:			Speci	'n₽aci	fic Islander
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene Hyber natural; or Iteme 23e or 28e-f ehow ent, Ite Madical Examiner must be notified at		15. Decedent's Ed	ducation		16a. Dece	dent's Usual Occ	upation		16	ib. Kind of E	3usiness/Ir	ndustry
212	Man 7	Completed	(Specify only highest gra		(1-4or 5+)	life.	kind of work don DO NOT use reti	e during most o red)	of working				
21.	giene	Son	6			Bar	ber						oming
2	be filed tal Hyg d other	Be (17. Father's Name (First, Middle, Last)							irst, Middle, Ma		me)	
<u> </u>	Men Marke Marke	٥	Cecilio Songco			101 14-11				Punluck		Canan 7	's Code's
<u>a</u>	12 sh h and 7 le n traun		19a. Informant's Name/Relationship (ng Address (Stre						
e,	1 and Healt em 2		David Songco/ Sc 20a, Method of Disposition	n	20b. F	Place of Dispo	Clover		Jane, Date	-	Mary Location		
ğ	de Et		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		1 State		natory or other p even Cemet	171	pril 2006	7,	ilver	Spri	ng, Maryland
Baltimore,	permit. Pages 1 and 2 should be file Department of Healint and Mental Hy Importent: If Item 27 ie marked other eny Injury or other traumatic event once.		21. Signature of Funeral Service Licer										
ä	Ded of the color		(inchen)	1	le	50 50	ancıs J 00 Unive	. Colli rsity B	ns Fu Blvd,	neral H W, Silv	dome Jer Sp	Inc. oring	MD 20901
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	lications that	caused the deat	h. Do not ent	er the mode of d	ying, such as ca	ardiac or re	espiratory arres	t,		Approximate Interval Between
	nysician		Immediate Cause (Final disease or condition	0	Cancer	_							Onset and Death
	/Medical		resulting in death)		o (or as a conseq								
	Examiner		Sequentially list conditions,	b									
	sit sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a consec	juence of):							
	xecut and at-tran	xan	that initiated events resulting in death) Last	c	o (or as a consec	quence of):							
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Вох	The law requires that the death certific te hes been signed by the ettending p tage 2 should be detached for use as i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		ulcome of pregna		Ectopic pregnar	icv				ate of deliv	
	ed for	sicia	in the past 12 months? 1 Yes 2 No		gnant at time of o		Other (specify)				, N	lonth	Day Year
P.O.	res that the de signed by the e l be detached i	Phy	9 Unknown			unition in the co	a daab ilaa aay aa	ours in Dard I		220 Did toba	200 HEQ 201	atributa to	the cause of death?
ŝ	signe bed	b	Part II. Other significant conditions of Valvular Heart I		death but not res	suiting in the d	ndenying cause	given in Faiti,			2 🗆 No		bably 4 Unknown
000	w requir been si should (etec							-				
3ec	hes hes	Completed								24a. Was an autopsy performe	ed?	death?	opsy findings available ompletion of cause of
ā			25. Was case referred to medical		,			OC Place	of Dooth (C	1 ☐ Yes 25		1 🗆 Yes	2 No
5	Physiclan: The la this certificate he ral director, page 2	To Be	examiner?	Hospital:	Inpatient 2	ER/Outpatier	at 3□DOA	Mh a m		5x Residen		ther (Spec	ify)
0	Attending Physician: r death. ector: After this certifici by the funeral director.		27. Manner of Death		e of Injury onth, Day Year)	28b. Time o				d. Describe how			,,
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Division of Vital Records,	f or Atten after deat Director: I in by the	Certification:	3 Suicide 6 Could not be determined	200. Plat	ce of Injury - At h ding, etc. (Speci	ome, farm, sti	reet, factory, offic	8	28f	. Location (Stre City or Town,		ber or Rui	ral Route Number,
	urs aft rel Di												
	To the Hospitel or At within 24 hours after on the Funerel Directompletely filled in by	Medical	29a. Certifier 1% Certifying Pl (Check only 2 Medical Example)	miner: On the									
	ithin 2	Med	29b. Signature and title of certifier	andina	anner stated.		29c. Lice	nse number		290	d. Date sign	ed (Month	, Day, Year)
	711		>)08/1 A	Boll	MI)		D5	3317		Ag	pril 4	, 20	06
	2 1		30. Name and address of person who										
			Joseph A. Ball,	M.D.	16220 Fi	rederio	k Road,	#213,	Gaith	nersburg	, MD	2087	7
		ate	31. Date filed (Month, Day, Year) APR 0.6.2	32	Registrar's Sign	ature	and s						
ð.	Regist	rar	APR 062	טטט 🚨	THE S	5 19	The state of the s						

			for State Registrar	State of Marylan	-	artment of H		d Mental Hy	/giene Reg. No.	006	12648
	Physici	an	Decedent's Name (First, Middle, Last DENIALL TABLET					2. Date of D Month	Day	Year	3. Time of Death
	/Medic		DINAH LADJE 4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of D	Apri		2006 County of Deat	23:14 M
	Examin	er	Shady Grove A		ni+ ol			odiii		ontgon	
	Funeral Director		5. Social Security Number 6. S			If Under 1 Year Months Days	Ville If Under 24 H Hours M	8. Date of B			hplace (State or Foreign luntry)
	pg a		Usual Residence of Decedent 10a. State 10b. County	10c Cib	, Town or Lo	cation					10d. Inside City Limits
	Maryla -f ehov lied at	tor	MD Montgo			ersburg					1 □X es 2 □ No
	h the	Director	10e. Street and Number	inc2 j		10f. Zip Code			10g. Citiz	en of What Co	untry?
	th wit	aiD	17709 Larchmo	nt Terr		208	77		U.S	S.A.	
5-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itema 23a or 28a-f show aumatic event, the Modical Examinar must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of F f Yes, specify Cub I ☐ Yes 2XNo	lispanic Origin? an, Mexican, Po Specify:	⁹ (Specity Yes or Nuerto Rican, etc.)		4. Race - Ame Black, Whit Specify: B]	e, etc.
	within 72 ho ene. than "natur ne Modical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 12th	ucation de completed) College (1-4or 5+)	(Give life. L	lent's Usual Occup kind of work done DO NOT use retire	during most of d)		Ced	d of Business/ ar Cre der Ca	eek Assoc
Maryland 2121	~ - 0 5	To Be Co	17. Father's Name (First, Middle, Last)	ckey	IVAL DI	119 1100	18. Mother's	Name (First, Middle Mamle	e, Maiden S	Surname)	-10
Mary	permit. Pages 1 end 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic e one.	-	19a. Informant's Name/Relationship (Anitra M. Simp	Type, Print) Son-Daughter	19b. Mailin	g Address (Street	and Number or	Rural Route Numi Te rr Ga	ber, City or ithe:	Town, State, 2	Zip Code) g, MD20877
ore,	ges 1 er t of Hea if item or other		20a. Method of Disposition 1	Removal from State	emetery, cren	sition (Name of natory or other pla	1	Date /7.0.		ation - City or	
Baltimore,	mit. Pa partmen portent: / injury		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral S → ice Licen		7 22		ss of Facility		Fune	eral i	oring, MD
ä	P P P P P P P P P P P P P P P P P P P	-	Leseyo ~	Suouds						ville,	MD20850
	Physician		23a. Part1. Enter the disease, or comshock, or hearnfailure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line. METASTAT				diac or respiratory	arrest,		Approximate Interval Between Onset and Death Years
	/Medical Examiner			Due to (or as a consequence).	uence of):						
	ate be executed hysicien and the burial-transit	Examiner	Sequentially list conditions, if any, leauling to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequ							
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.O. Box (at the death certifica by the attending ph tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnanc Other (specify)	/		20	3d. Date of del Month	ivery Day Year
_	as the gned be de	þ	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the un	nderlying cause giv	ren in Part I.				the cause of death?
Records,	fhe law requir te has been si age 2 should I	Completed						24a. Wa auto peri 1 □ Yes	opsy ormed?	24b. Were au prior to death? 1 \(\sum \) Yes	itopsy findings available completion of cause of
a		BeC	25. Was case referred to medical				26. Place of I	Death (Check only		1 103	241 NO
>	S 0	70 8	examiner? 1 ☐ Yes ② 【☐ No	Hospital: 1∑Inpatient 2□	ER/Outpatien	t 3□ DOA Ctf	er: 4 🗌 Nursin	g Home 5 ☐ Res	idence 6	☐Other (Spe	cify)
o uc	ding Afte fune		27. Manner of Death t Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2∐No	28d. Describe	how injury	occurred	
Division of Vital	or Attenter ter deat Irector: Irector: Irector:	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		me, farm, stre		103 2	28f. Location City or To	(Street and own, State)	Number or Ru	ıral Route Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical C	29a. Certifier (Check only one) Certifying Ph	ysician: To the best of my knowniner: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the tile vestigation, in my o	ne, date and pl pinion, death o	ace, and due to the courred at the time	cause(s) a	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date	signed (Monti	h, Day, Year)
•	10		Paul Rama			MD06	0335		Apr	il 5,	2006
	•		30. Name and address of person who Mr. Paul Banne	completed cause of death (Item	23a) (Туре,	Print)	ip Dr	#327 O1	nev.	MD 20	0832
	Sta	te.					-t Dr	11027 01			
	Registr	-	31. Date filed (Month, Day, Year) APR 0 6	32. Régistrar's Signat	IF A	MARCO					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year APRIL 4, WILLIAM SHULMAN 2006 2:45 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3200 North Leisure World Blvd. #304 Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1**X** M 2□ F Days Hours Min. Director 131-09-7952 June 5, 1914 New York Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 successions to the substance of the 1 XYes 2 No Maryland Montgomery Silver Spring 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3200 N. Leisure World Blvd., # 304 20906 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Army If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: WW 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Years Elementary/Secondary (0-12) Internal Revenue Service U. S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Morris Shulman Rose Singer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) <u>Mildred M. Shulman - Wife</u> 3200 N. Leisure World Blvd., # 304, Silver Spring, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3X Removal from State 4/7/2006 Arlington Hat'l Cem. 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc. Donald (1170 Rockville Pike, Rockville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 Years Immediate Cause (Final disease or condition resulting in death) Metastatic Melanoma Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by Cerebrovascular Disease 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Artereosclerotic Cardiovascular Disease certificate 2 🗆 No 1 ☐ Yes 2 **X**No 1 TYes Division of Vital or Attanding Physician: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 x Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 2 1 ☐ Yes 🍇 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) á 4 Homicide To the Hospitel o within 24 hours aft To the Funeral Di 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mulinner stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) ولي D08381 0 April 4, 2006 ho completed cause of death (Item 23a) (Type, Print) 30. Name and address of person w Dr. Benjamin Avrunin 18111 Prince Philip Drive, Suite 209, Olney, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 6 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** 2.300 Annis 2 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner polis, Anna Drundel MID Medica If Under 1 Year If Under 24 Hrs. 5 Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min 229-44-7904 1 ☐ M 2 🔀 F 92 Director Feb. 16, 1914 Minnesota Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic avant, the Modical Examiner must be notified at Maryland Anne Arundel Annapolis 1 Yes 2010 Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.
Important: If itam 27 is markad othar than "natural", or Itams 23a or 2 any injury or othar traumatic avant, the Mudical Examiltant in ust be no once. 9101 River Crescent Drive 21401 U.S.A. Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. ☐Yes 2x2No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 20XNo Specify: If Yes, Give Year or Dates: Š Specify: White 3XXWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Aaron Gould Katherine Pearson 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Roy C. Smith, IV/son 320 Upper Mountain Avenue Montclair, NJ 07043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Coremation 3 ☐ Removal from State Ft. Lincoln Crematory: 4/4/2006 A □ Donation 5 □ Other (Specify) Brentwood, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home neral Serv 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Hear bloc hous disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760, attending physician Physician/Medicai as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year ó in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the detached 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy co or Attanding Physician: director. 25. Was case examiner? referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Certification: To 6 ☐Other (Specify) this 28a. Date of Injury (Month, Day Year) filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After ' 1 Natural 2 ☐ Accident 5 Pending investigation 1 🗌 Yes 2 □ No death. Diractor: 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Momicide within 24 hours a To tha Funaral L Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D006178 30. Name and address of rerson who completed cause of death (Item 23a) (Type, Print) 2001 MO 32 Registrar's Signature 31. Date filed (Month, Day, Year) State APR 0 4 2006 Registrar

			1 - For State Registrar	State of N	/larylan	d / Depa <i>Cei</i>	artmen <i>tificat</i>	t of H e <i>of L</i>	ealth a	and M		giene Reg. No.	106	maga-saa	265	Mary accompany
4 3	Physici	an	1. Decedent's Name (First, Middle, Las	•							2. Date of De		Year		3. Time of De	ath
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	with th	Dire	10e. Street and Number 1610 Marlboro	2.4			10f. Zip	Code 103	7				n of What Co	ountry	1?	
	Jeath The 23	erai	11. Marital Status	12. Was Deceden	nt Ever in U.	S. 13. \				gin? (Spe	ecify Yes or No	US - 14	Race - Ame	encan	Indian,	
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ylar	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, I in M.	To B	George E. Seske	er					Sara	ah E	Sell	lman				
Maryland	nd 2 shi lith and 27 is m traum		19a. Informant's Name/Relationship (7) Penell T. Seske								i <i>l Route N</i> umbi dgewat	-				
Je,	of Hea Item		20a. Method of Disposition		20b. P	া lace of Dispo ভাষতা				-	Date		tion - City or			
Baltimore,	Page ment cant: It		1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		e DC	Par	k		į 2	1-7-			polis		Md.	
Bai	Penell T. Sesker (Wife) 20a. Method of Disposition 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Signature of Funeral Service Licensee 23. Part 1. Enter the disease, of complications that caused the death. Do not enter							d Addres eese est	s of Facility St.	sons Ann	Mortu	uary,	P.A.	401		
8760,	Physician /Medical Examiner supplysician and physician and the prival-transit	dical Examiner	shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or a	s a consequence a consequence	uance of):	Arry	/lon	110	*					terval Betweenset and Deat	
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a		0	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes	2 No	1 🗌 Yes	2[□ No	
<u>></u>	hysica his ce	To B	TE THIS INC	Hospital: 1 ☐ Inpat		ER/Outpatien	3□ DO	A Othe			ne 5□Resid		Other (Spe	cify)		
Division of	of attending Physician: after death. Director: After this certific d in by the funeral director.	ation:	27. Mapmer of Death T Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, D	jury ay Year)	28b. Time of Injury	М 2	Bc. Injury Work 1 ☐ Y	at ? ′es 2 □ N		28d. Describe I	ow injury o	ccurred			
DIVIS	- 0 -	Certification:	3 Suicide 6 Could not be determined	289. Place of II	njury - At ho etc. (Specify	me, farm, stre	eet, factory	, office		2	28f. Location (5 City or Tox	Street and N vn, State)	lumber or Au	iral R	oute Number,	
	To the Hospital o within 24 hours aft To the Funeral Di completely filled in	edical	29a. Certifier (Check only one) Certifying Physical Exam	rsician: To the besiner: On the basis and manner s	of examinati	wledge, death ion and/or inv	occurred a estigation,	at the time in my op	e, date and inion, deat	i place, a h occurre	and due to the o	cause(s) and date and pla	d manner as ice, and due	state to the	ed. e cause(s)	
	To the To the comp	M	29b. Signature and title of certifier					License		v.			igned (Monti			
•			CA CA	OPRA	4	70-1 7	I	57	8025	8	Ansay	MAR	ch ?	51	200 (2
			DR Cho PRO	122 0.	death (Item	AUR	. Su	ite	#23	3/	ANNE	polis.	md.	11:	401	
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 4 200	32. Regis	trar's Signat	ure	AL.						1 G			

State of Maryland / Department of Health and Mental Hygiene | 15 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Year Vera DeVore Sirna MARCH 17, 2006 6:03 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CUMBERLAND ALLEGANY MEMORIAL HOSPITAL If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) MARCH 3, 1 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 C F 1922 84 Director 217-18-4252 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 23a or 28a-f ehow the Medical Examiner must be notified at CUMBERLAND 1X Yes 2 □ No Director ALLEGANY 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 220 Sommerville Ave., Apt. 513 21502 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. filed within 72 hours after 1 ☐ Yes 21 No If Yes, Give Year or Dates: 1 Never Married 2 Married 9 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: ģ WHITE 3 N Widowed 4 □ Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Retail Appliance at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) BUSINESS MANAGER Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if Item 27 is marked oth eny linjury or other traumatic event 2008. Be Bessie May Baxter Earnest William Whitman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 26753 Route 1, Box 3, Ridgeley, WV Carol Susan Albin / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Patrick's Cem. 03/21/2006 Cumberland, MD St. 21. Signature of Funeral Service License 22. Name and Address of Facility
Upchurch Funeral Home, P.A. 21502 202 Greene Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Finat disease or condition resulting in death) Discontinuation Physician Dialysis /Medical Due to (or as a consequence of): Examiner to thrive ailure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed hronic Rena physicien a s the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical houric Rena attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 **N**o 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an hes 1 ☐ Yes 2 **P** No Be 25. Was case referred to medical director 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA this After this funeral of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Matural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a
To the Funeral C
completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature and title of certifie

N.A. Ransit

31. Date filed (Month)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 2006

DHMH 17 Rev 1/2001

4

m.b. 57701dta

32. Resistrar's Signature

29c. License number

D19318

29d. Date signed (Month, Day, Year)

un Rd. Cumberland MD 2002

			1 - State Amend # 17 &	State of Mary 18 , 4-12-	land/Depa)6, per	artment of H HDR HCH Tillicate of	lealth and De <i>ath</i>	Mental Hy	/giene Reg. No	006	12653
	Dhysisi		1. Decedent's Name (First, Middle, Last)					2. Date of D Month	eath Da	y Year	3. Time of Death
	Physici /Medio		Gene Y. Suh					April	5,	2006	7:25 P M
	Examin	er	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or		ath		. County of Death	
-			Casey House 5. Social Security Number 6. Security	7 Age //n	yrs. last birthday)	Rockvill	e If Under 24 H	rs. 8. Date of B		ontgomer	
	Funeral Director			M 2□F	47 Yrs.	Months Days	Hours Mi		ay, Year) 4, 1	958 Kore	place (State or Foreign ntry) a
	and		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	ocation				1.	10d. Inside City Limits
	Maryl f eho	Po	Maryland Montgomer		aithersb						1 tv Yes 2 □ No
	1 the	Director	10e. Street and Number			10f. Zip Code			10g. Cit	tizen of What Cou	ntry?
	h with		511 Pensacola Driv	<i>r</i> e		20878			USA		
	eme er m	Funeral		12. Was Decedent Ever Armed Forces?		Was Decedent of H	ispanic Origin?	(Specify Yes or N	0-	14. Race - Americ Black, White,	
36	s afte	by Fu	1 Never Married 2 Married	1 □Yes 2 🛣No If Yes, Give		1 ☐ Yes 2 🛣 No	Specify:	, , , , , ,		Specify:	GIG.
Ö	hour ture!	ed b	3 Widowed 4 Divorced	Year or Dates:	16a Dece	dent's Usual Occup	ation		16b K	Asia (ind of Business/In	
<u>.</u>	within 72 hours after deeth with the Maryland ene. then "naturel", or iteme 23e or 28e-f ehow the Medical Examinar must be rediffed at	Completed	(Specify only highest grade	e completed)	(Give	kind of work done of DO NOT use retired	during most of w	rorkin g	100. K	and or business/in	dustry
212	d with giene	E O	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	Engine	eer			Nuc	lear Scie	ence
Maryland 21215-0036	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)					ame (First, Middle	e, Maiden	Sumame)	
y a	Meni	၉	Tae il Suh Yong	Tae-il Sub			-Sook H			Young Hal	
ā	d 2 sh d 2 sh th and 7 is n treum		19a. Informant's Name/Relationship (Ty Yonghun Charles St			ng Address (Street : Saleroso			-	·	
<u>ő</u>	1 en Heali tem 2		20a. Method of Disposition			sition (Name of matory or other place				ocation - City or To	
<u></u>	ages ent of nt: If I		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emovar nom State	_	natory or other plac se Cremat	1 -	ril 7, 2006	Re1	tsville.	Maryland
Baltimore,	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Iteme 23a or 28a-f ehow eny Injury or other treumatic event, the Madical Examinat must be notified at once.		21. Signature of Funeral Service License	99// //	GG	Name and Address	ss of Facility Cremat:	ion Serv	ice	P.O. Box	x 784
			23a. Part1. Enter the disease, or compli	cations that caused the						arksville	Approximate
	Physician		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line. Metastati	o Colon (ancer					Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a co		Jancer		-			
	Examiner		Sequentially list conditions,).							
	pe sit	lner	if any leading to in mediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	neaduence of):						
_	xecute and Il-tran	Examiner	that initiated events resulting in death) Last	Due to (or as a co	nsequence of):					- 1	
68760,	icate be executed physicien and the burial-transit	dicalE			,						
9											
P.O. Box	that the death certifined by the attending of the detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pi 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)				23d. Date of delive Month	ery Day Year
	es that igned b be deta	by Pt	Part II. Other significant conditions cor	ntributing to death but no	t resulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco i	use contribute to the	he cause of death?
ğ	w require been sig should b							10	Yes 2	∑ No 3□Prob	oably 4 ⊟Unknown
lecc	8 8	Completed						24a. Was	psy	prior to co	psy findings available mpletion of cause of
<u> </u>								pen 1 ☐ Yes	ormed? 2 No	death? 1 ☐ Yes	2 □ No
Ĭ	Physicien: rthis certifica ral director, I) Be	25. Was case referred to medical examiner? 1 ☐ Yes ※※※ No	lospital:		Othe		eath (Check only		- VP1	
ō	g Phy er this eral d	n: To	27. Manner of Death	28a. Date of Injury	2 ER/Outpatier		4 ∐ Nursing	28d. Describe) Hospice
<u>o</u>	Attending Phir death.	atlo	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	ar) Injury		<br Yes 2 □ No				
Division of Vital Records,	F & F C	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, str pecify)	eet, factory, office		28f. Location City or To	(Street an wn, State	nd Number or Rura a)	al Route Number,
	To the Hospitel of within 24 hours af To the Funerel D completely filled in	edical (29a. Certifier 1X Certifying Physical Consecutive 2 Medical Examination (Check only one)	sician: To the best of my ner: On the basis of exa and manner stated.	y knowledge, death mination and/or in	n occurred at the time vestigation, in my op	ne, date and place pinion, death oc	ce, and due to the curred at the time.	cause(s) , date and) and manner as s d place, and due to	tated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. License	number		29d. Da	te signed (Month,	Day, Year)
)			I Chilie ly	myone		D4245	2		Apri	1 6, 2006	5
(1	2) Jm		30. Name and address of person who co	mpleted cause of death		Print)					
1	Sta Registr		31. Date filed (Month, Day, Year) APR 0 7 20	32. Registrar's S							

			1 - For State Registrar	State of Mar		epartment of Certificate o			giene 0 0	6 12654
	Physici	an	Decedent's Name (First, Middle	,				2. Date of Dea		3. Time of Death
	/Medic			Anastasios	Samara			March		06 1400 M
	Examin	er	4a. Facility Name (If not institution,		H. Ca.	4b. City Town	or Location of De	eath	4c. County o	1
	Funeral		5. Social Security Number		In yrs. last birti	nday) If Under 1 Yea		Its. 8. Date of Birtl in. (Month, Day	h	9. Birthplace (State or Foreign
	Director		216-20-5159	1 X M 2□ F 79) Y	rs. Months Day	rs Hours Mi	in. (Month, Day 5/30/]	(, Year) 1926	Country) Ohio
	D *		Usual Residence of Decedent 10a. State 10b. County	1.	I0c. City, Town	or Location				
	Aaryla Fahor	ō		comico	Delma					10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	28a-1	Director	Maryland Win	COULTGO	Dering	10f. Zip Code			10g. Citizen of W	hat Country?
	3a or		30317 Mallard	Drive			875		USA	
	death	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. Was Decedent o	of Hispanic Origin?	(Specify Yes or No-	14. Race	- American Indian,
õ	or Ita		1 Never Married 2 Marrie			1 □ Yes 2 2 N		ono moan, etc.,	Specify:	k, White, etc. White
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<u>.</u>	in 72 n "ne fadic	Completed	(Specify only highes	t grade completed)		Give kind of work don life. DO NOT use reti	ne during most of wired)	vorking	16b. Kind of Bus	anessindustry
7	d within giene. ir then the Max	E o	Elementary/Secondary (0-12)	College (1-4or 5+)		.esman			Automot	tive parts
and	2 should be filed void and Mental Hygie Is marked other freumatic evant, it	BeC	17. Father's Name (First, Middle, L					lame (First, Middle,	Maiden Surname)
<u>X</u>	should but nd Ment	To		asios Samaras				Palovis		
Mar.	and 2 sh salth and n 27 Is m		19a. Informant's Name/Relationsh Stella Samaras/1		19b.	Mailing Address (Stre BO317 Malla	et and Number or and Dr.,	Delmar, M	r, City or Town, S 1D 21875	State, Zip Code)
sammore,	t se T is t		20a. Method of Disposition 1		cemetery W1COI	Disposition (Name of crematory or other p	ial 4/	Date /5/06	20c. Location - C	City or Town, State
Dali	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service L		Park		y Funeral W Hill Ro	l Home Pro	ofessiona oury, MD	al Association 21804
Ī			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that caused the only one cause on each line.		ot enter the mode of d	lying, such as card	lac or respiratory ari	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. LNTRA Due to (or as a c		BRAL	HEMA	CORAG	尼	
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	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	consequence o).				
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200	ath ce	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2	Fetal death	3 ☐Ectopic pregnar			23d. Date Mont	of delivery th Day Year
5	the e	ysic	1 ☐ Yes 2 ☑No 9 ☐ Unknown	4□Pregnant at tin 9□Unknown	ne of death	5 Other (specify)			Widn	ii Day regi
	that the ed by detac		Part II. Other significant condition	As contributing to death but	not resulting in	the underlying cause of	given in Part I.	23e. Did to	bacco use contrib	bute to the cause of death?
cords,	The law requires that the death certificate be executed ate has been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit	d by						1 🗆 Y	es 2 No 3	3 ☐ Probably 4 ☐Unknown
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č	rsician: The law s certificete hes b lirector, page 2 s	шо			-			autops perfor		nor to completion of cause of eath?
VIIA	etor,	Bec	25. Was case referred to medical examiner?				26. Place of D	eath (Check only or		
5	hysia this ca al dire	2	1 ☐ Yes 2 No	Hospital: 1 Inpatient				Home 5□ Resid		
=	After	lon:	27. Manner of Death Natural 5 Pending		rear) 28b. Ti	ury W	juryat /ork? □Yes 2 □No	28d. Describe h	ow injury occurred	d
NSIOII N	death ctor; y the	licat	2 ☐ Accident investigation in	ot be Diago of Joine	- At home, far	m, street, factory, offic		28f Location (S	treet and Number	r or Rural Route Number,
2	s after s after al Dire	Certification:	4 ☐ Homicide determine	building, etc. ((Specify)	n, anout, motory, and	~	City or Tow		or rigigal ribate reambor,
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funerel Director; After this certificate his completely filled in by the funeral director, page	edicai ((Check only one)	Physician: To the best of examiner: On the basis of examiner state	xamination and	death occurred at the or investigation, in my	time, date and play opinion, death oc	ee, and out to the courred at the time, d	auto(t) and man late and place, an	nor as stated. nd due to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier			29c. Lice	nse number	2	9d. Date signed	(Month, Day, Year)
	al.		1	~	In	- 00	00584	110	4/	1/06
	Biz		30. Name and address of person v	the completed cause of dear	th (Item 23a) (1				MICRIA	Ry mo 21201
	Sta	te	31. Date filed (Month, Day, Year)	- 32. Registrar's	s Signature	MARIONA	UUUD	C1. 3/1	- 130017	1 100 0100
	Registr		APR 0	5 2006 Magaza	. K	Someth 1				

		4	For State Registrar	State of M	Marylan		artment of F				iene)	16	12655
Phy	siciar		1. Decedent's Name (First, Middle, La	•	a '		-			2. Date of Deat Month	Day	Year	3. Time of Death p
/Me	edica	1			Smith		4b. City, Town, o		-f D- oth	April :		fy of Death	
Exa	mine	r	4a. Facility Name (If not institution, git 4376 Smith Road	e street and numbe	,		Salish		or Death			COMic	
Fune	ral				Age (In yrs. I	ast birthday)	If Under 1 Year	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Dey,			place (State or Foreign intry)
Direct				1 ☐ M 2 🗗 F	76	Yrs.	Months Days	Hours	Will.	6/13/19	929	Mary	
land		- 1	Usual Residence of Decedent 10a. State 10b. County		10c. City	r, Town or Lo	cation						10d, Inside City Limits
Many Ff sh		5	Maryland Wicomi	co	Sa	alisbu	ry						1 ☐ Yes 2X☐ No
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene and Mental Hygiene is marked other than "natural", or items 23s or 28s-1 show aumatic event. The Model Exeminar must be notified at	1	5	10e. Street and Number 4376 Smith Roa	d			10f. Zip Code 2180)1		10	0g. Citizen of U	f What Cou	intry?
death		Funeral	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U.	S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Ori	igin? (Spec	city Yes or No-			ican Indian,
)36 Irs after II', or Ite		DA La	1 ☐ Never Married 2 【X Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 If Yes, Give	No			Specify:		iican, etc.)	Spec	^{ify:} White	
5-0(72 hou natura) led	15. Decedent's E (Specify only highest gr	ducation		16a. Deced	dent's Usual Occup	ation	t of workin	0	16b. Kind of	Business/Ir	ndustry
dthin a		Completed	Elementary/Secondary (0-12)	Cottege (1-4c	or 5+)		kind of work done of DO NOT use retired	1)	i or working		Calia	0111011	University
Hygie ther			17. Father's Name (First, Middle, Lasi	-		Casi	iner	18. Mothe	er's Name	(First, Middle, N			oniversity
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mental Hygiene. T' is marked other time "natural", or required other time "natural", or required event, the Modical Event	0	10 De	James Edward Smi						sey Cr				
2 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5		THE STREET	19a. Informant's Name/Relationship Alan D. Smith/hu				ng Address <i>(Street o</i> 5 Smith R						p Code)
altimore, mit. Pages 1 ar partment of Hea portant: If item;			20a. Method of Disposition 1 X Burial 2 □ Cremation 3 [te c	emetery, cren	sition (Name of natory or other plac emetery		4/6/0		20c. Location	-	own, State
Baltin permit. P. Departme Important	3	-	'4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice		01.1	22	Name and Address	ss of Facilit Funer	al Ho	ome Prof	Siloam Session	nal A	ssociation
u aosa		-	23a. Part1. Enter the disease, or con	pompo		SP:	001 Snow	Hill	Rd.,	Salisbu	ıry, M	218	04 Approximate
Physicia	an		shock, or heart failure. List only tmmediate Cause (Final disease or condition	one cause bn each	line.	-	Ce/c			-	, , ,		Interval Between Onset and Death
/Medic Examin			resulting in death)	-	as a consequ						_		years.
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8760, ate be executed hysicien and the burial-transit	E Icolo		Tooling in dociny 2001	Due to (or a	as a consequ	ience or):							
687	100	בַּב		u									
P.O. BOX 68760, nat the death certificate be executed by the attending physicien and eached for use as the burnat-transit	Dhysiolan/Mo	ysiciarium	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcon 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)					ate of delivionth	ery Day Year
	40 74		Part II. Other significant conditions	contributing to death	but not resu	Ilting in the ur	nderlying cause give	en in Part I.		23e. Did tob	acco use cor	ntribute to t	he cause of death?
Cords w require been sig	7									1 □ Ye	s 2 No	3 🗌 Prot	pably 4 Unknown
has has		ald III								24a. Was an autopsy perform	red?	prior to co death?	opsy findings available impletion of cause of
		ע	25. Was case referred to medical					26 Place	of Death	1 Yes 2	ZINO	1 🗌 Yes	2 No
Of VI Physici this cer al direc	a c	0	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	itient 2 🗆	ER/Outpatien	t 3 DOA Othe			e 5 Reside		her (Specif	(y)
ION O nding Pt th. : After th	-dolar		27. Manner of Death 1 ØNatural 5 ☐ Pending 2 ☐ Accident investigatio		njury Day Year)	28b. Time of Injury	28c. Injun World	/at <br Yes 2 □ I	28	3d. Describe ho			
DIVISION Of VITA Hospital or Attending Physician: 94 hours after death. Funeral Director. After this certific iety filled in by the funeral director.	Cortification.		3 Suicide 6 Could not to determined	28e. Place of	Injury - At ho etc. (Specify		eet, factory, office		28	Bf. Location (Str. City or Town,		ber or Rura	al Route Number,
To the Hospital of within 24 hours a To the Funeral Completely filled is	1 0		29a. Certifier (Check only one) Certifying Plants 2 Medicel Exe	nysician: To the bearing: On the basis and manner	of examinat	wiedge, death ion and/or inv	occurred at the time restigation, in my of	ne, date an pinion, dea	d place, an	nd due to the ca	use(s) and m te and place,	anner as s , and due to	atated. the cause(s)
To the Hos within 24 h To the Fur	Me		29b. Signature and little of certifier	1/wit	- M.	0	29c. License		0	1	d. Date sign		Day, Year)
08	3		30. Name of address of person		f death (Item	23a) (Type,							7, MD.
2	State			11 12 7 / 32. Regis	strar's Signat	ture	1756	· . C.	-1-01	/ //.	2011	550	7,19.
	istrai		APR 0 6	2006 32. Regis	Peter e	K. A	made a						
DHMH 17 Rev	1/200	1				19							

			For State of	Maryland / Dep	partment of H	lealth and N	Mental Hyg	giene 🔠	6	12656
			1 - For State Registrar	Ce	ertificate of l	Death		Reg. No.	0	12000
	Physicia		1. Decedent's Name (First, Middle, Last) Gorcion / Thra	sher Jr			2. Date of Dea	Day	Year 06	3. Time of Death 12:5713 M
	/Medic Examin		4e. Facility Name (If not institution, give street and num	ber)	4b. City, Town, pr	Location of Death		4c. County	of Death	
			5/9 Caroline Street	Age (In yrs. last birthday	-	erland If Under 24 Hrs.	9 Date of Birt		gan	
	Funeral Director		5. Social Security Number 218-60-2427	53 Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Day Apr 7,	953	9. Birth	place (State or Foreign ntry)
	and *		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or L	Location					10d. Inside City Limits
	Maryl	tor	MD Allegany	Cumi	berland					Y□Yes 2□No
	within 72 hours after death with the Maryland ene. Ithan "natural", or Itema 23e or 28a-f show he Medical Ezam nar must be notified at	by Funeral Director	10e. Street and Number		10f. Zip Code	4500		10g. Citizen of		ntry?
	leath v na 23e must	erai	519 Caroline Street 11. Marital Status 12. Was Deced	dent Ever in U.S. 13.		21502 Ispanic Origin? (Sp	pecify Yes or No-	US		can Indian,
ထ္	after d or Item miner	Fun	Armed Ford 1 ☐ Never Married Ž☐ Married 1 ☐ Yes, Give	;es? 2 ☐ No	I. Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puero	Rican, etc.)		ck, White,	etc.
ဓ္က	hours tural',	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Da	tes:	edent's Usual Occupa			16b. Kind of B	white	
215	hin 72 an "na Medic	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-	(Give	re kind of work done of DO NDT use retired	during most of world)	king	160. Killa of b	usinessm	oustry
21	filed wit Hygiene other the	Com	12 17. Father's Name (First, Middle, Last)		rapher	18. Mother's Nam		Alliant T		Systems
and	ld be fi ental H ked of ic aver	To Be	Gordon L. Thrasher, Sr.				shoop Th		ie)	
Maryland 21215-0036	2 should and Men is marke raumatic		19a. Informant's Name/Relationship (Type, Print) Lora Thrasher wife		iling Address (Street a		ral Route Numbe			21502
	1 and 3 Health tem 27 other tr		20a. Method of Disposition		position (Name of ematory or other place		Date	20c. Location		
Ē	Pages nent of I int: If its iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from S 14 ☐ Donation 5 ☐ Other (Specify)	Sunset Men	morial Park	· 9)	4/14/2006	Cumbe	rland	MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural; or liema 23e or 28a-f show any injury or other traumatic avent, the Medical Exam are must be notified at once.		21. Signature Funeral Service Licens e	11111 2	22. Name and Addres Scarpelli					
	403 6 G		23a. Party. Enter the disease, or complications that ca	used the death. Do not er	108 Virgi nter the mode of dyin	nia Avenue g, such as cardiac	: Cumberla or respiratory are	and, MD 2	21502	Approximate
B	Pnysician		shock, or heart failure. List only one cause on ea Immediate Cause (Final disease or condition	osclerotic	Cornago	Vasc	day Dis	12.04		Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (c	or as a consequence of):	Co. Dave.	7	2,0			,
		Je.	Sequentially list conditions, if any, leading to immediate Due to (conditions)	or as a consequence of):					-	
H	acuted Ind transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
760,	icate be executed physician and s the burial-transit	cal E)	Due to (c	or as a consequence of):						
9	rtificate ng phy: as the		IF FEMALE:							
Box	that the death cértifical ed by the attending phi detached for use as th	by Physician/Med	23b. Was decedent pregnant 1 Live bit		☐Ectopic pregnancy				te of deliv	ery Day Year
o.	the de	hysic	1 Yes 2 No 9 Unknown		Other (specify)					
<u>г</u> ,	w requirds that been signed b should be deta		Part II. Other significant conditions contributing to dea	ath but not resulting in the	underlying cause give	en in Part I.		obacco use con ′es 2 □ No		he cause of death?
Sord	v requi	eted					24a. Was a			opsy findings available
Re	Physician: The law requirds that the death cértifica this certificate has been signed by the attending phrai director, page 2 should be detached for use as the	Completed					autop	med2	prior to co death? 1 Yes	mpletion of cause of
/ita	cian: ertifica octor, p	Be	25. Was case referred to medical examiner?		Ott.	26. Place of Dea				
			1 Yes 2 No Hospital: 1 ☐ In	nationt 2 PR/Outpatic		9r:	ome 5 Resid	ence 6 Oth	or (Conni	(v)
οţ	Physic rthis corral dire	: To		·	ent 3 DOA Other	4 Nursing H	28d. Describe h			,
ion of	anding Physicath. Pr.: After this cone funeral dire		27. Manner of Death 1-X Natural 5 Pending (Month) 2 Accident investigation	·	of 28c. Injun	4 Nursing H				<i>n</i>
Jivision of	utending death. ctor: After y the fune		27. Manner of Death 1- Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be 28e. Place	·	of 28c. Injury Work	/ at	28d. Describe h	ow injury occur	red	al Route Number,
Division of Vital Records, P.O. Box	utending death. ctor: After y the fune	Certification:	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28. Date of (Month investigation of Death) 4 Homicide 28. Place of Death 28. Date of (Month investigation of Death) 4 Homicide 28. Place of Death 28. Date of (Month investigation of Death) 4 Certifying Physician: To the	I Injury , Oay Year) 28b. Time Injury of Injury - At home, farm, s g, etc. (Specify) best of my knowledge, dea	of 28c. Injuny Work M 1 1 3	y at ⟨? Yes 2 □ No	281. Location (S City or Tow	ow injury occur Street and Numb m, State) cause(s) and m	per or Rura	al Route Number,
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by Funeral Director	213-26-6406 Usual Residence of Decedent 10a. State Maryland 10b. County Carc 10e. Street and Number 20810 Frazier Poi	ast) rapnell ive street and number) int Lane Sex 1 \(\text{N} \) 2 \(\text{SF} \) coline		Certi	ificate d	of Death n, or Location of Death on ar If Under 24 Hrs	2. Date of E Month March h	Reg. No Death Da 28	y Year	3. Time of Death 2330 M
Funeral Director	Margaret L. Tr 4a. Facility Name (If not institution, gr 20810 Frazier Po. 5. Social Security Number 213-26-6406 Usual Residence of Decedent 10a. State 10b. County Maryland Carc 10e. Street and Number 20810 Frazier Poi	rapnell ive street and number; int Lane Sex 1 M 2 M F	ge (In yrs. last 74	t birthday) Yrs.	Presto	on ear If Under 24 Hrs	Month March	28 4c	2006	
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y Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Carc 10e. Street and Number 20810 Frazier Poi	oline	74	Yrs.	Months Da	ys Hours Min.	(Month (17 (71	Caroline 9. Birthi	
y Funeral Director	Maryland Card 10e. Street and Number 20810 Frazier Poi		10c. City, To				May 1	Day, Year)	931 Te	place (State or Foreign ntry) NNESSEE
y Funeral Director	Maryland Card 10e. Street and Number 20810 Frazier Poi		Toc. City, 10				-			
y Funeral Dire	20810 Frazier Poi			OWN OF LOCA		Preston				1 ☐ Yes 2 2 No
y Fune					10f. Zip Coo	21611			U.S.A.	
×	11. Marital Status	12. Was Decedent Armed Forces	?	13. Wa	as Decedent Yes, specify (of Hispanic Origin? (S Cuban, Mexican, Puer	pecify Yes or Note Rican, etc.)	10-	 Race - America Black, White, 	
0	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ★ ★ Divorced	1 ☐ Yes 250 If Yes, Give Year or Dates:	_	1 🗆	□Yes 2🔀	No Specify:			Specify: Wh	ite
	15. Decedent's E	 Education		6a. Deceder	nt's Usual Oc	cupation		16b. K	ind of Business/In	dustry
omple	(Specify only highest g.		5+)	life. DC	O NOT use re	tired)	rking		Nursing	·
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		L1/son				The state of the s				
		☐Removal from State	ceme	etery, crema	itory or other	place)			•	
			Glen							
	21. Signature of Fundral/Service Lice	ensee	1000							
	23a. Part1. Enter the disease, or cor	mplications that cause	d the death. D						iaports,	Approximate Interval Between
	shock, or neart failure. List onf Immediate Cause (Final disease or condition resulting in death)	a. SPONT	ANTONS		ENTRA	CEREBRAL	KET	WRR	LHARE	Onset and Death
miner	Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	s a consequenc	ice of):						
ш	resulting in death) Last	Due to (or as	s a consequent	ice of):						
slclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1∏Live birth 4∏Pregnant a	2 Fetal dea	ath 3□E					23d. Date of delive Month	ery Day Year
Ph		contributing to death t	but not resulting	na in the unde	erlying cause	gryen in Part I	23e. Did	tobacco i	use contribute to the	ne cause of death?
d b	-	, and the second			,					
lete							24a W6	6 20	24h Word 2010	ney findings available
μŭ							aut	opsy formed?	prior to co	
a	25. Was case referred to medical	J				Of Plans of Day			1 Lives	2 No
m	examiner?	Hospital: 1 Dippatie	ient 2□FR/	/Outpatient	3[] DOA				XXOthor (Second	scene
	27. Manner of Death			b. Time of						y),
atlo	1 XNatural 5 ☐ Pending 2 ☐ Accident investigate		ay rear)	injury						
Sertific	3 ☐ Suicide 6 ☐ Could not determined	a 289. Place of In	njury - At home, tc. (Specify)	, larm, stree	ot, factory, off	ice	281. Location City or To	(Street and	d Number or Rura	al Route Number,
	29a. Certifier 1 ☐ Certifying F (Check only one) 1 ☐ Certifying F 2 ☑ Medical Example 1 ☐ Certifying F 2 ☑ Medical Example 2 ☐ Medical Example 2	aminer: On the basis of	of examination	dge, death o and/or inves	occurred at the stigation, in r	e time, date and place ny opinion, death occu	, and due to the irred at the time	e cause(s) , date and	and manner as s d place, and due to	tated. o the cause(s)
Σ	29b. Signature and title of certifier				29c. Lic	ense number		29d. Da	te signed (Month,	Day, Year)
	> Umas2)CME		Ma	rch, 29,	2006
	· ·		death (Item 23	Ba) (Type, Pri	•					
		1 - /			111 F	enn Street	: Balt:	lmore	, Maryla	nd 21201
	To Be Completed by Physician/Medical Examiner To Be Completed	17. Father's Name (First, Middle, Last William Kyle Had William Kyle Had 19a. Informant's Name/Relationship Henry R. Trapne. 20a. Method of Disposition 1	17. Father's Name (First, Middle, Last) William Kyle Hagood	William Kyle Hagood 19a. Informant's Name/Relationship (Type, Print) Henry R. Trapnell/son 20a. Method of Disposition 1 Remail 2 Cremation 3 Removal from State 4 Donation 5 Other (Specity) 21. Signature of Fundral pervice Licensee 23a. Part1. Enter the disease, or complications that caused the death. Indicate the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Secuentially list conditions if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequent of the personal line of th	William Kyle Hagood 19a. Informant's Name/Relationship (Type, Print) Henry R. Trapnell/son 20a. Method of Disposition 128Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature Fruntral Service Licensee 22. 147 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease) or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease) or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease) or condition resulting in death) 25cuentially list nonditions from the latter of the latter of the latter of the latter of the latter of lines. 26cuentially list nonditions resulting in death) 27cue to (or as a consequence of): 28cuentially list nonditions resulting in death) 29cue to (or as a consequence of): 29cue	William Kyle Hagood 19a. Informant's Name/Relationship (Type, Print) Henry R. Trapnell/son 20a. Method of Disposition 1	Name Part Name (rist, Maction, Last) Name (rist, Maction, Last) Name (rist, Maction) Name of Control N	18. Monther's Name (Frest, Modific, Last) 18. Monther's Name (Frest, Modific, Last) 18. Mailing Address (Street and Number or Rural Route Number, City of Henry R. Trapnell/son 190. Mailing Address (Street and Number or Rural Route Number, City of 1200 Fostoria Way Gaithersburg, 200. Place of Department of 120 place of Department of 120 place of Department of 120 place of Department of 120 place of Department of 120 place of Department of 120 place of Department of 120 place of Department of 120 place of Department of 120 place of Department of 120 place of Department of 120 place of Department of 120 place of Department of 120 place of Department of 120 place of Department of 120 place of Department	Securior Securior	

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** James McMahan Tarwater Month April 3 2006 10 23 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2□F Yrs. Director 414-12-6165 88 Dec. 11, 1917 Tennessee Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or Itams 23a or 28a-f ehov traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2√2 No Director Maryland Frederick Ijamsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11397 Canary Drive 21754 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. e filed within 72 hours after if Hygiene. other than "natural", or Ita 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: If Yes, Give Year or Dates: 1940-64 þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Career Military Officier U.S. Navy permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any njury or other traumatic event ones. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Matthew Atkin Tarwater Ida-Mae McMahan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Self by pre arrangement 11397 Canary Drive, Ijamsville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Mt. Olivet Cemetery 04/06/06 4 ☐ Conation 5 ☐ Other (Specify) Frederick, Maryland 21. Signature of Foreral Service Libensee 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home Morest 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS WITH SHOCK **Physician** 6HOURS /Medical Examiner ENTEROCCAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit death certificate be executed CHRONITE Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery ned by the attent detached for u 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ PROSTATE CANCER 1 Yes 2 No 3 Probably 4 Unknown Completed PERTONSLOW 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? CORONARY ARTERY DISTEASE 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 patient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director; After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Medicai 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D46075 415106 Mars P. Howell mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 65-C Thomas Johnson Drive, Frederick, Maryland Mary P. Howell, M.D. 31. Date filed (Month P.D., Charty 2006 32 Registrar's Signature State Registrar

			1 - For State Registrar	State of Marylar			nt of H		ind Mei		giene Reg. No.	006	and the state of t	559	
1	Physici	an	Decedent's Name (First, Middle, La						2.	Date of De Month	Day	Ye	ar	e of Death	,
	/Medic	al	BERTHA 4a. Facility Name (If not institution, giv	TURNBU	JLL	4b Cit	Tour or	Location of		pril	5	2006 County of D		5 A	М
	Examin	ier	FRIENDS NURSING					SPRIN			40.		rgomery		
香	Funeral Director		5. Social Security Number 6. S 066 05 9904		last birthday) Yrs.		er 1 Year	If Under 2 Hours		Date of Bir (Month, Da Ily 1,	1908		Birthplace (Sta Country) EW YORK	te or Fore	ign
	Maryland	or	Usual Residence of Decedent 10a. State 10b. County MD. PRINCE (ty, Town or Lo		GTON							e City Limi	
	with the Page or 28a-	i Director	10e. Street and Number 12504 SURREY CIF	RCLE DRIVE		10f. 2	ip Code 20744					en of What	•		
036	be filed within 72 hours after deeth with the Maryland tal Hyglene. d other than "natural", or itame 23a or 28a-f ehow avent, I'ra Mudigal Enarchar must be notitled at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 Mo If Yes, Give Year or Dates:	1		edent of Hi ecify Cuba 2 X No	ispanic Origi in, Mexican, Specify:	in? (Specif Puerto Ric	y Yes or No can, etc.))-	4. Race - A	mencan Indiar hite, etc.		
9500-61212	I within 72 ho lene. r than "natur	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give	kind of v	use retired	durina most (of working			nd of Busine			
yland 2	buid be filed w Mental Hygier arked other th atic avent, the	To Be C	17. Father's Name (First, Middle, Last, FREDERICK HEITKA					CATH	HARINE		, Maiden TERM	Sumame) ANN			
, mary	and 2 shoulealth and Market Is market		19a. Informant's Name/Relationship (DOROTHY ENGLEKIN)	G, DAUGHTER	12504	1 SUF	RREY (e, Zip Code) N,MD.20	744	
saltimore,	permit. Pages 1 and 2 should b Department of Health and Menta Importent: If Item 27 is marked any injuryor other traumatic a once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Fernation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of the content	Removal from State	Place of Dispo cemetery, crei COPOlit	matory of	other plac		Date 1/05/0				or Town, State	1	
gall	permit. Departi Importe any infi		21. Signature of Funeral Service Licer	W. Bar	10			BARBE 5038,				MD 2	N882		
	Physician /Medical Examiner	ā ļ	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	th. Do not ent	ter the me	ode of dying	g, such as c	cardiac or re	espiratory a	rrest,		Approxi Interval Onset a	nate Between nd Death WEF	K
8/60,	certificate be executed nding physicien and use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consecutive to d.											
O. Box 62	c 2 -	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ₺ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of o	al death 3	Ectopic Other (pregnancy specify)				2	3d. Date of Month	delivery Day	Year	
coras, r	w requires that the death been signed by the atte should be detached for	þ	Part II. Other significant conditions of	contributing to death but not res	ulting in the u	nderlying	cause give	en in Part I.		23e. Did t			e to the cause		vn
Ž.	The la ate has page 2	Completed								24a. Was autop perfo		24b. Were prior death		gs availab f cause o	le f
VII	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 29 No	Hospital:	50/0 · ·		Othe			heck only c					
	ding After fune	-	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury Work	or ANurs or at to? Yes 2 No	28d	5 Aesii Describe I			Specify)		
DIVISION	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification:	2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined	e Ros Bloss of Injury As h	ome, farm, str y)					Location (S City or Tox		Number or	Rural Route N	umber,	
	he Hospi in 24 hour he Funer plately fill	edicai	29a. Certifier (Check only one) Certifying Ph	rysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, death	occurre vestigation	d at the tim on, in my op	e, date and pinion, death	place, and occurred a	due to the at the time,	cause(s) date and	and manner place, and o	as stated. due to the caus	e(s)	
	To t To t	Σ	29b. Signature and title of certifier	^		7	9c. License					_	onth, Day, Yea		
	4		- KINAN	- JR	- 00-1 7		723	124		· · · · · · · · ·	4PRJ	L 5	,200	6	
	1		30. Name and address of person who	DN M 290			AND	4 SPR	MIR	RD	ON	JEM	MAG	MIA	MA
19 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Sta	-	31. Date filed (Month, Day, Year)	32 Registrar's Sign		refer	A-71-0	1 2116	1, 4	100	- View	- 1)	1.11	ا لسيار ب	150
	Registr	ar	APR 0.6.20	JUD FEBRUARY	0 8										

			For State C		artment of Health and tificate of Death		Date of the same	12660
			Decedent's Name (First, Middle, Last)		interes of Double	2. Date of Death		3. Time of Death
	Physici /Medic		ARLINE CROFT TOWER			April 4,	^{Day} 2006 Year	4:05 AM
9	Examin		4a. Facility Name (If not institution, give street and nu Wilson Health Care Cen		4b. City, Town, or Location of Dea Gaithersburg	th	4c. County of Death Montgome	
_	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs	8. Date of Birth	_	place (State or Foreign
	Director		213-50-4201 1□M 2\\ F	85 Yrs.	Months Days Hours Min	8. Date of Birth (Month, Day, Ye Sept. 15	,1920 Cana	ida
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
	Maryl -f sho fied	ţō	Md. Montgomery	Gaithersh	ourg			1 X Yes 2 ☐ No
	th the or 28a e noti	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Cou	ntry?
	eth wi	rai	333 Russell Ave. #201		20877		Inited Sta	
36	permit. Pages 1 and 2 should be tited within 72 hours after deeth with the Maryland Department of Health and Mantal Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or pthe traumatic event, the Medical Examiner must be notified at once.	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Dec Armed F 1 Never Married 2 Married 1 Pes G Year or I	2∑No ive	Vas Decedent of Hispanic Origin? (: f Yes, specify Cuban, Mexican, Pue I ☐ Yes 2 🏿 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White, Specify: Whi	etc.
2	72 hou	sted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupation	ndking 161	b. Kind of Business/In	ndustry
2	vithin 7	Completed		1-4or 5+) Homen	kind of work done during most of wo DO NOT use retired) naker	nang	Own Home	
2	Hygie Hygie thar t	CO	17. Father's Name (First, Middle, Last)			me (First, Middle, Mai		
an	lid ba tantal rkad c	To Be	Lloyd Croft		Myrt1	e Meadows		
Maryland 21215-0036	2 shou and N Is ma		19a. Informant's Name/Relationship (Type, Print)	0				Code)
	tealth sm 27		Deborah Tower Fretwell 20a. Method of Disposition	803 E		a, Califor	nia 94510 c. Location - City or To	own State
Baltimore,	Pages then of the tant: If ite		1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State Metropoli	tan Crem. Apr	:i1 5,	exandria,	
Bal	permit Depar Impor any In once.		21. Signature of Funeral Service Licensee Curtus & Day		Name and Address of Facility De East Deer Park			d. 20877
			23a. Part1. Enter the disease, or complicate hs that shock, or heart failure. List only one cause on immediate Cause (Final	each line				Approximate Interval Between Anset and Death
	Pnysician /Medical		disease or condition a	(or as a consequence of):	lure to The	, i		X Wille
Ė	Examiner		Sequentially list conditions, b.		eddenne	itea		
	tad sit	nine	rf any, leading to immediate cause. Enter Underlying Cause (Disease or injury	(or as a consequence of):				
	fficate be executad g physician and as the burial-transit	Examiner	that initiated events c	(or as a consequence of):				
68760	nte be nysicia ne bur	edicai	d					
_	- FB #	/Med	IF FEMALE;	atcome of pregnancy				
P.O. Box	it the death certiff by the attending p tachad for use as	Physician/M	in the past 12 ments?	birth 2 ☐ Fetal death 3 ☐ nant at time of death 5 ☐	Ectopic pregnancy Other (specify)		23d. Date of deliver	ery Day Year
	that if	by Ph	Part II. Other significant conditions contributing to c	leath but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobac	co use contribute to t	he cause of death?
rds	w requires that s been signed t should be deta	ed b				1 ☐ Yes	2 No 3 Prot	bably 4 □Unknown
Vital Records,	The la	Completed	······································			24a. Was an autopsy performed	prior to co death?	opsy findings available impletion of cause of
/ita	Physiclan: Th r this certificate ral director, pag	Be (25. Was case referred to medical examiner?		Tou /	ath (Check only one)		
	Physic r this c	- T	27. Man r of Death 28a. Date	Inpatient 2 ER/Outpatien of Injury 28b. Time of		Home 5 Residence		(y)
lon	nding th. :: After	ation	1 ZNatural 5 ☐ Pending (Mor 2 ☐ Accident investigation	oth, Day Year) Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		,,	
Division of	al or Atter s after des il Diractor id in by the	Sertification;	3 Suicide 6 Could not be 28e. Plac	e of Injury - At home, farm, stro ling, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rura tate)	al Route Number,
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifice completely filled in by the funeral director.	edical C	(Check only 2 Medical Exeminer: On the b		n occurred at the time, date and plac vestigation, in my opinion, death occ			
	To the within To the comp	Me	29b. Signature and title of certifier	. /	29c. License number	29d.	Date signed (Month,	Day, Year)
)	10		1 Haberton	sellade	4 204115	4	erelt,	2004
			30. Name and address of person who completed cau	HBALLY N	Print) 2012 Lij GAIT	24SSSL YEKSBU	IRG MU	2007
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 6 2006	Registrar's Signature	whi.			

			1 - For State Registrar	State of N	/larylan			nt of He te of D		nd Me		giene Reg. No.	UUD	126	61
			1. Decedent's Name (First, Middle, Last)							2. Date of Dea	ıth		3. Time o	of Death
	Physici /Medio		HARRIET CECELIA THIBAD	EAU							APRIL 3.	Day 2006		5:00	P M
	Examir		4a. Facility Name (If not institution, give	street and numbe	r)		4b. City	Town, or	Location of E		,		County of De		
			BRIGHTON GARDENS NURSI	NG HOME			ROCKV	ILLE				MON	TGOMERY		
	Funeral		Social Security Number 6. Se		Age (In yrs. I	ast birthday)	If Unde Months	r 1 Year Days	If Under 24 Hours	Hrs.	8. Date of Birtl (Month, Day	Year)	9. 8	Birthplace (State Country)	or Foreign
	Director		214-60-6423]M 2[X]F	96	Yrs.	IVIOITIII	Days	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					RTH DAKOT	Α
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside (City Limits
	faryli eho	ō													s 2 No
	the Marylan 28a-f ehow notified at	Director	MARYLAND MONTGOMERY 10e. Street and Number		SILV	ER SPRII		p Code				10a Citi	zen of What	Country?	
	with so a						101. 21							Country:	
	eath	Funeral	707 SHERBROOK DRIVE 11. Marital Status	12. Was Deceder	nt Ever in II	S. 13 V	Was Dece	20904		n? (Spec	ify Yes or No-		J.S.A.	merican Indian,	
	iter d	Ë	1 Never Married 2 Married	Armed Forces	s?		If Yes, spe	cify Cuban	, Mexican, P	Puerto R	lican, etc.)		Black, W		
936	urs a	Ď	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	_		1 ☐ Yes	2 🖺 No	Specify:				Specify:	WHITE	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-1 ehow ha Mazleal Examinar must be notified at	Completed	15. Decedent's Edu	cation		16a. Dece	dent's Usu	al Occupa	tion			16b. Ki	nd of Busine		
218	thin 7	pie	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4o	r 5+)	life.	DO NOT L	ise retired)	uring most of	i workin	9				
21	giene.	го	12			SECRETA	ARY					DEPA	RIMENT C	F EDUCATI	ON
nd	al Hygie I other	Be	17. Father's Name (First, Middle, Last)						18. Mother's	s Name	(First, Middle,	Maiden	Sumame)		
Va	Ment Ment mrkec	To	CHRISTIAN ANDERSEN NORI	DBY					HILDA			LIES	SHAGEN		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla I Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-1 ehov other traumatic event, the Medical Examinar must be notified at	8]	19a. Informant's Name/Relationship (T)	rpe, Print)		19b. Mailir	ng Addres	s (Street a	nd Number o	or Rural	Route Numbe	r, City o	r Town, State	, Zip Code)	
	and ealth m 27		ANDREW L. THIBADEAU/SON	N					E, SILV		PRING, M				
ore	T Ser I		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☒ F	Removal from Stat		lace of Dispo emetery, crer	natory or	me of other place)	Da	ite	20c. Lo	cation - City	or Town, State	
Ë	tant: Pa		4 ☐ Donation 5 ☐ Other (Specify)			INGTON 1	NATION	AL CEM	04/	/27/2	006	ARLIN	IGTON, V	IRGINIA	
Baltimore,	permit. Pages 1 and 2 should be file Department of Health and Mental Himportant: If Item 27 is marked oth any injuy or other traumatic even once.		21. Signature of Funeral Service Licens	00		HIN	Namea NES-RT	nd Address NALDT	s of Facility FUNERAL	. НОМ	E. INC.				
	707 4 0		"Umanda Ji	idewig		118	300 NE	W HAMP	SHIRE A	AVENU	E, SILVE		RING, MA	RYLAND 20	
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	ications that caud ne cause on each	ed the death line.	i. Do not ent	er the mo	de of dying	, such as cai	ardiac or	respiratory an	rest,		Approxima Interval Be Onset and	etween
1	Enysician		Immediate Cause (Final disease or condition	ATHEROSCI	LEROTIC	HEART I	DISEAS	Е						YEARS	Doam
	/Medical Examiner		resulting in death)	Due to (or a	is a consequ	ience of):								1	
в	*	پد		b. Due to /or o	is a consequ	vanna of):									
	led Isit	를	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	000 10 (01 6	is a consequ	erice or.									
	xecurand al-tra	Examine	that initiated events resulting in death) Last	c Due to (or a	is a consequ	ience ol);									
8760,	The law requires that the death certificate be executed ate has been signed by the ettending physicien and cage 2 should be detached for use as the burial-transit	<u>a</u>													
687	ficate physis the	edical		0											
Box	eath certific ettending p for use as	N/	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcom								1	23d. Date of o	delivery	
m	death e ette	cial	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant	at time of de]Ectopic p] Other (s,						Month	Day	Year
P.O.	that the deed by the detached	Physician/M	9 Unknown	9□ Unknown											
	s that ned t	V P	Part II. Other significant conditions co.	ntributing to death	but not resu	ulting in the u	nderlying	cause give	n in Part I.		23e. Did to	bacco u	se contribute	to the cause of	death?
Records,	requires been sign should be	Completed by	HYPERTENSION								1 🗆 Y	es 2[□No 3□	Probably 4 🛚	Unknown
000	s been s been s shoul	ojet	CEREBRAL VASCULAR ACCID	ENT							24a. Was a		24b. Were	autopsy findings o completion of	s available
æ	The lav	E									autop: perfor	med?	death	o completion of ? es 2 \(\subseteq \text{No}	cause of
Vital		0	25. Was case referred to medical						26. Place of	f Death	Check only or			63 20110	
\geq	w :5	To B	examiner? 1 ☐ Yes 2 ☒ No	fospital: 1 ☐ Inpa	tient 2 🗆 1	ER/Outpatien	nt 3□ D	Othe	-		e 5 ☐ Resid	360	S □Other (S	pecify)	
Jou	ding Phys h. After this funeral di		27. Manner of Death	28a. Date of In (Month, D	jury Jav Year)	28b. Time of Injury		28c. Injury Work			Bd. Describe h				
Ö	Attending it death.	atic	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(////////	, , , , , , , , , , , , , , , , , , ,	,,	М		es 2□No						
Division	r Attender death rector:	Certification:	3 Suicide 6 Could not be determined	28e. Place of I	njury - At ho etc. (Specify	me, larm, str	eet, factor	y, office		28	Bf. Location (S City or Tow	treet an	d Number or	Rural Route Nu	mber,
	ital or A														
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medicai	29a. Certifier (Check only one) 1 \(\times \) Certifying Phy 2 \(\times \) Medical Exami	sician: To the bes nar: On the basis and manner:	of examinat	wiedge, death ion and/or in	occurred vestigation	at the time n, in my opi	e, date and p inion, death o	place, ar occurred	nd due to the o d at the time, o	ause(s) late and	and manner place, and d	as stated. ue to the cause	(s)
	To the within To the comple	Ž	29b. Signature and title of certifier	7			29	c. License	number		· ·	9d. Dat	e signed (Mo	nth, Day, Year)	
	16		1/m/2			Jan	3 .	33357				DD T T	4, 2006	<u> </u>	
	12		30. Name and address of person who co	ompleted cause of	death (Item	23a) (Type,		/ ((((Į A	ENIL	→ , ∠000	J	
			LEE JONATHAN MUSHER, M				UE, SI	JITE 10	045, CHI	EVY C	CHASE, MA	RYLA	ND 2081	5	
	Sta		31. Date filed (Month, Day, Year) APR 0 6 2	32. degis	strar's Signat	K A	arte	,							
	Registi	ar	MEIN UU E		Crown or										

			1 - For State Registrar	State of Ma	aryland /			nt of H te of L		and M		giene Reg. No	000	125	62
П	.		1. Decedent's Name (First, Middle, Last)								2. Date of De Month	ath Da	y Year	3. Time o	of Death
	Physici /Medio		LOUISE O. TAYLOR								APRIL 4,			5:00	Р М
	Examin	ner	4a. Facility Name (If not institution, give si				4b. Cit	, Town, or	Location of	of Death		4c.	County of Dea	ath	
			SUNRISE ASSISTED LIVING		- // /	In inth of a col		MBIA er 1 Year	If Under	24 Hrs	8. Date of Birt		OWARD	mb-1 /04-4-	
	Funeral Director		5. Social Security Number 6. Sex 1□	M 201F	e (In yrs. last 91	Yrs.	Months		Hours	Min.	(Month, Da	y, Yea <i>r)</i>		rthplace (State Country) TH CAROLI	
			Usual Residence of Decedent								TIM1 13,	1714	[300]	II CAROLI	IVA
	how		10a. State 10b. County		10c. City, To	own or Los	cation							10d. Inside C	
	B Ma	ctor	MARYLAND MONTGOMERY		SILVER	SPRIN	G							1 Tes	2 📉 No
	or 28	Director	10e. Street and Number				10f. Z	ip Code				10g. Cit	izen of What C	country?	
	aih w 23a		2508 REDMILES DRIVE					20905					U.S.A.		
2	d within 72 hours after death with the Maryland siener than natural, or items 23e or 28e-1 show the Madical Examiner must be notified at	y Funeral	1 Never Married 2 Married	 Was Decedent I Armed Forces? Yes 2 X I If Yes, Give 		lf If	Yes, sp	edent of Hisecify Cubar	spanic Ori n, Mexicar Specify:	i, Puerto	ecify Yes or No Rican, etc.)	-	14. Race - Arr Black, Wh Specify:		
0-0-0	ural',	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:								10) 16	10	WHITE	
5	n 72	Completed	15. Decedent's Educ (Specify only highest grade	completed)		(Give I	kind of v	ual Occupa ork done d use retired;	<i>urina</i> mos	t of work	ing	16b. K	ind of Busines	s/Industry	
7	within the net	шо	Elementary/Secondary (0-12)	College (1-4or 5				VE AID				नतत्त्रम	RAL GOVE	DNMFNT	
2	be filed ntal Hygi ed other event.	Be C	17. Father's Name (First, Middle, Last)	·						er's Name	(First, Middle,			MILITAL	
	uld be Mental rked o	To B	JASPER WI	LLIAMS					ADA		ROG	ERS			
<u> </u>	2 should and Men Is marke eumatic		19a. Informant's Name/Relationship (Typ	e, Print)	1	9b. Mailin	g Addre	ss (Street a	nd Numbe	er or Run	al Route Numbe	er, City o	or Town, State,	Zip Code)	
Σ ນົ	and 2 ealth n 27 I		NORMAN H. TAYLOR/SON						VE, SI		SPRING,				
ב	S S E E		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re	emoval from State	20b. Place ceme	of Dispos etery, crem	sition (N natory or	ame of other place	9)		Date	20c. Lo	ocation - City o	r Town, State	
	ment of little lury or of lury or		4 ☐ Donation 5 ☐ Other (Specify)		PARKL	AWN ME				04/07	/2006	ROCK	VILLE, MA	ARYLAND	
	permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygie Important: If tem 27 is marked other it any injury or other treumatic event. In once.		21. Signature of Funeral Service License	e dours		HI	NES-R		FUNER	ÁL HC	ME, INC.				
			23a. Part1. Enter the disease, or complic	eations that caused	the death [RING, MA	RYLAND 20	
			shock, or heart failure. List only one	e cause on each lin	ne.	oo not onto	or (110 III	odo or dy m	g, 300m d3	oardiao (or respiratory a	11031,		Interval Be Onset and	tween
	hysician /Medical		disease or condition resulting in death)	_ALZHEIME] Due to (or as			-						- 15	5 YEARS	5
	Examiner			Due to (or as	a consequent	ce or).									
1		je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a sunsaquen	se of):									
	cuted nd ransit	Examiner	that initiated events												
Š	e exe	EX	resulting in death) Last	Due to (or as	a consequent	ce of):									
0/00	cate be executed physicien and the burial-transit	dlcai	d.												
		/Me	IF FEMALE:	3c. If yes, outcome	of pregnancy								20d Date of d	- ti	
202	Ihat the death certified by the attending detached for use as	by Physician/Me	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal dea	ath 3□		pregnancy specify)					23d. Date of d Month	Day	Year
		hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown											
ν L	requires that the een signed by th hould be detache	y P	Part II. Other significant conditions con-	tributing to death b	ut not resultin	g in the ur	nderlying	cause give	n in Part I		23e. Did t	obacco (use contribute	to the cause of	death?
ğ	w requires I been signe should be										10	Yes 2	⊠No 3□F	robably 4]Unknown
ນ	¥ 20 S	ple									24a. Was	an	24b. Were a	autopsy findings completion of	s available
ב	The ete h page	Completed									perfo 1 ☐ Yes	rmed?	death?	s 2 No	
	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?					100		of Deat	(Check only o	ne)			
5	Phys this aldi	ျ	1 ☐ Yes 2 Ñ No	ospital: 1 Inpatie 28a. Date of Inju		Outpatien b. Time of			4 🗆 140		me 5 Resi			ecify) ASSIS	TED G
	2 je 2	ion	1 ☑Natural 5 ☐ Pending	(Month, Da	y Year)	Injury	м	28c. Injury Work	at ? ∕es 2□		Zou. Describe	now anju	ry occurred		
DIVISION	or Attending after death. I Director: After d in by the fune	Certification:	3 Suicide 6 Could not be	28e. Place of Inj	ury - At home	, farm, stre								Rural Route Nur	m <i>ber</i> ,
	2 4 4 5	Cert	4 Homicide determined	building, et	u. (эрөспу)						City or To	wii, Stafe	2)		
	호수구	Medical (29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best er: On the basis of and manner sta	f examination	dge, death and/or inv	occurre vestigation	d at the time on, in my op	e, date an inion, dea	id place, ith occuri	and due to the ed at the time,	cause(s date and) and manner a d place, and du	as stated. le to the cause	(s)
	To the f within 2 To the f complet	¥	29b. Signature and title of certifier	Ma	100	Λ	2	9c. License	number			29d. Da	te signed (Mo	oth, Day, Year)	
	6			KVL.	I.M	ノ.		D56531				APRII	5, 2006		
			30. Name and address of person who cor												
			HARRY LI, M.D., 10780 H. 31. Date filed (Month, Day, Year)		E ROAD, ar's Signature		BIA,	MARYLA	ND 210	044					
	Sta Registi		APR 0 6 20			4	Sec.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For Stete Registrar	State of Marylan		tificate of			eg. No.	2663
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)	Truitt				2. Date of Dear	3, 2000	3. Time of Death 51.30 A M
	Examin Funeral	er	4a. Facility Name (If not institution, give s Compared to the compared to t	Treet and number) HOSDITOI 7. Age (In yrs. M 2XIF 85		4b. City, Town, of Sunday 1 Year Months Days	If Under 24 Hrs Hours Min	s. 8. Date of Birth	4c. County of Dea	oth M/CU httplace (State or Foreign ountry) ryland
	Director		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	Yrs. y, Town or Lo			11///1	920 Ma	10d. Inside City Limits
	death with the Maryland me 23a or 28a-f show crrust be neitling at	Direct	Maryland Wicomic 100. Street and Number 1311 Emerson Ave.	0 5	Salisbu	10f. Zip Code 2180	7	1	0g. Citizen of What C	12 Yes 2 No ountry?
0036		by Funeral		2. Was Decedent Ever in U Armed Forces? 1 Yes, 2 No If Yes, Give Year or Dates:			lispanic Origin? (an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Whi	
N-C1212	I within 72 hours after jene. r then "natural", or ite ine Medical Exemine	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wo d)	orking	16b. Kind of Business Bookkeepi	
land		To Be C	17. Father's Name (First, Middle, Last) Alvin C. Hubbert				18. Mother's Na	um <i>e (First, Middle, I</i> urggraf	Maiden Sumame)	
, Mary	and 2 should ealth and Mer n 27 is marke		19a. Informant's Name/Relationship (Typ. James G. Truitt/h	usband	131	l Emerso		Salisbury	r. City or Town, State, 7, MD 2180]	
baltimore	Pages 1 ment of Hi ant: If iter ury or oth		20a. Method of Disposition 1 □ Burial 2 □ Sremation 3 □ Re 4 □ Donation 5 □ Other (Specify)		cemetery, cren	sition (Name of natory or other pla Cremato	ry 4/4		20c. Location - City of Salisbury,	
gall	permit. Departi Import. any inj once.		21. Signatura of Funeral Pervice Cense	low-						Association 804
3	Frigorous personned by Medical physician and physician and sthe pural-transit	Examiner	232. Parv. Enter the disease, or comblishock, or heart failure. List only on immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dicease of in the that initiated events resulting in death) Last	COROMINA	Uproce of): Uproce of): Uproce of): Uproce of of other order of other order of other order of other order of other other order of other order or		eg.SC	as or respiratory arm	851.	Approximate Interval Between Onset and Death
, P.O. BOX 68/60	death certif e attending ed for use as	y Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ac. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	ll death 3 [Ectopic pregnanc Other (specify) _		23e. Did tol	23d. Date of de Month	Day Year
Hecords,	G & CA	Completed by						1 □ Ye 24a. Was a autops perfori	24b. Were a	robably 4 Unknown utopsy findings available completion of cause of
or Vital	ysician: The secutificate director, pag	To Be	27. Man of Death	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien	I 3LI DOA	ner: 4 🗆 Nursing	1 ☐ Yes : eath (Check only on Home 5 ☐ Reside	2 Ø No	s 2 No
DIVISION	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the puppletely filled in by the funeral	Certification:	1 Natural 5 Pending 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specif	Injury ome, farm, stray)	M 1 🗆	Yes 2 □No	28f. Location (Si City or Town	treet and Number or R n, State)	ural Route Number,
	To the Hospital within 24 hours a Vithin 24 hours a To the Funerel Completely filled in the Funerel	edical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my known; or: On the basis of examina and manner stated.	owledge, death	occurred at the treestigation, in my contraction, i	me, date and place opinion, death occ	ce, and due to the courred at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
•	To the within To the Comp	Me	29b. Signature and title of certifier	D MA		29c. Licen:	28640		9d. Date signed (Mon	
	Sta	to.	30. Name and the ss of person who can be seen a second of the second of	ppleted cause of death (Item 70.50/74/ 32. Prigistrar's Signa	enter	Print)	alisbu	4, MD		
	Sta Registr		APR 0 5 20	ns As	N A	Comment of				

Aplease Type of Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** LLOOAM 30,20do Milton ()mbenhauer arch Damuel /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) THE Examiner* BROOKE GROVE ASSISTED LIVING MEADOW SANDY SPRING MONTGOMERY | Months | Days | Hours | Min. | March | 20, 1 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1 ☐ M 2 ☐ F 1907 Tennessee Director 050-07-5858 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show iner riust be notified at 1 X Yes 2 ☐ No Maryland Montgomery Sandy Spring Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20860 1641 Hickory Knoll Road. # 8 Items 23a U. S. A. Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or itee ary or other traumatic event, Ite Medical Examination ☐ Yes 2 No Yes, Give X 1 Never Married 2 Married 1 ☐ Yes 2 H No Specify: Baltimore, Maryland 21215-0036 Specify: White ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Engineering Firms Engineering Executive 18. Mother's Name (First, Middle, Maiden Sumame)

Lucile May 17. Father's Name (First, Middle, Last) Be -Lucy May Milton S. Umbenhauer ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20861 17621 Tree Lawn Drive, Ashton, Maryland Carol G. Ames - Daughter Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State 20a. Method of Disposition permit. Pages Department of I Important: If it any injury or o once. 1 ☐ Burial 2 X Cremation 3 X Removal from State 4/4/2006 Metropolitan Crem. Alexandria, Virginia * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Danzansky-Goldberg Memorial Chapels, Inc 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASPIRATION Physician PNEUMONIA DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DYSPHAGIA Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events to (or as a consequence of Examiner EREPLOVASCULAR DISEASE attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No 4☐ Pregnant at time of death 5 Other (specify) of Vital Records, P.O. 9 Unknown 9 Unknown s been signed by t 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. λq 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy 1 Yes 2 No or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 StOther (Specify) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 25KNo Certification: To After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Division 1 Natural 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier 30. Name of address of person who completed cause of death (Item 23a) (Type, Print)

CRACE BROOKE HURGMAN MP. 18100 SLADE SCHOOL ROAD SANDY SPRING MARYLAND

31. Date filed (Month, Day, Year)

32 Registrar's Signature 20 31. Date filed (Month, Day, Year) APR 0 6 2006 32 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** April 14 2006 ear 11:00 P.M. Annie Marie Windle /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Harford Aberdeen 208 Darlington Avenue If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Bay, Year) Mar. 9, 1934 9. Birthplace (State or Foreign Virginia **Funeral** 1 □ M 2 🗙 F Director 72 Yrs 229-42-0071 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is markad other then "naturel", or items 23a or 28e-f shov other traumatic event, the Medical Exyminer must be notified at Director MD Aberdeen 1 XYes 2 No Harford 10e, Street and Number 10g. Citizen of What Country? U.S.A. 10f. Zip Code 21001 208 Darlington Avenue death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22000 If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Item eny injury or other treumatic event, the Medical Exylander. Black, White, etc. 1 Never Married 200 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specily: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Frances Wright Toney A. Goad 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Abordoon Marvland 21001 19a. Informant's Name/Relationship (Type, Print) William Floyd Windle (Spouse) 20b. Place of Disposition (Name of cametery, crematory or other place)
Draper Valley Pen. Certi. 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from State Draper, Virginia ° 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Arlen Physician Disease LOYOMAN >10 UM /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed the attending physician and hed for use as the burial transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Hospitel or Attending Physiclan: 24 hours after death. Funerel Director: After this certifics 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospitel within 24 hours a To the Funerel D for Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Winaw D 32609 4/17/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1106 Revolution St. Kamrudin Milham Mo Harre De Graer mp 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2006

			- For Amend Items 25,27,28a	/land / Depai - f per ME <i>Cerl</i>	TOBS 404 718	aith and Me 3/06dhb eath	ental Hygie Reg	ane U5	12666
П	Dhunini		1. Decedent's Name (First, Middle, Last)		_		2. Date of Death Month	Day Ye	3. Time of Death
	Physicia /Medic		Marie Dail Wingate				February		
	Examin		4a. Fecility Name (If not institution, give street and number)		4b. City, Town, or L	ocation of Death		4c. County of	Death
			Chesapeake Woods Center			oridge		Dorch	
	Funeral Director		217-42-6173 1□M 2月F	n yrs. last birthday) 97 Yrs.		Hours Min.	8. Date of Birth (Month, Day,) May 19,	1908	Birthplace (State or Foreign Country) Maryland
	pu \star		Usual Residence of Decedent 10a, State 10b, County 10	0c. City, Town or Loca	ation				10d. Inside City Limits
	e Maryla ia-f sho	Director	MD Dorchester	20. Gity, 10 Wil Ol 2004	Cambridge	2			1 ☐ Yes 2 🛣 No
	th th)Ire	10e. Street and Number		10f. Zip Code		100	g. Citizen of Wha	it Country?
	23a	al [722 Hills Point Road		216	513		USA	
2	be filed within 72 hours atter death with the Maryland hat Hygiene. Add other then "natural", or items 23e or 28e-f show event, it a Madical Examitrat must be modified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Eve Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		/as Decedent of Hisp Yes, specify Cuban, ☐ Yes 2⊠ No	panic Origin? (Spec Mexican, Puerto R Specify:	cify Yes or No- lican, etc.)		American Indian, White, etc. White
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	othe	Be C	17. Father's Name (First, Middle, Last)		1	8. Mother's Name	(First, Middle, Ma	iden Sumame)	
ğ	ould be Mental arkad o	10	Willie S. Dail			Elsie Wi	lson		
<u> </u>	W		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Street an	d Number or Rural	Route Number, (City or Town, Sta	te, Zip Code)
	and 2 ealth a n 27 is nertrai		Mary Jane Barnes daughter		Green Cov		ide, M	21613	
ש	00	Ì	LESOUTIAL 2 CHEMIATION 3 CHEMIOVALITOTII STATE	20b. Place of Disposi cemetery, crema Dorchester		1		oc. Location - Cit	
Dall	permit. Pages Department of Importent: If it any injury or o		21. Signature of Funeral Service Licensee	22.	Name and Address O Locust	of Facility Tho	mas Fune	ral Home	e P.A.
	Inysician /Medical Examiner	ner	23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter the charm. Due to (or as a condition or	onsequence of):	matoma				Interval Between Onset and Death
,00,00	licate be executed physician and s the burial-transit	edical Examiner	Cause (Disease or injury that initiated events c. Due to (or as a continuity of the	onsequence of):	CEF	TIFICATION	D BY MEDICAL		
0	titica ng ph as th		TE SERVICE						
.O. Box	The law requires that the death certil the law requires that the attending tite has been signed by the attending bage 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ NO 9 ☐ Unknown 23c. If yes, outcome of 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3 E	Ectopic pregnancy Other (specify)			23d. Date o Month	f delivery Day Year
Ĺ	res that signed b I be deta		Part II. Other significant conditions contributing to death but n	ot resulting in the unc	derlying cause given	in Part I.	23e. Did toba	cco use contribu	te to the cause of death?
2	uires n sigr Id be	d by	Cerebral Vascular a	socident	-		1 ☐ Yes	2 No 3	Probably 4 Unknown
oi vilai necorus,	The law requir te has been si age 2 should	Completed					24a. Was an autopsy performe	prio dea	e autopsy findings available to completion of cause of th? Yes 2 \sum No
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>	Physicien: this certitics ral director.	O B	examiner? 1 Pres 2 No Hospital: 1 Inpatient	2 ER/Outpatient	3□ DOA Other:	4 Nursing Hom	e 5 🗆 Residen	ce 6 Other (Specify)
DIVISION O	ding Ph h. Atter th tuneral	Certification; T	27. Manner of Death 1 Statural 2 X Accident 28a. Date of Injury (Month, Day Young) 1730/2006		28c. Injury a Work? 1 □ Ye	t 21	8d. Describe how Subject	fell ge	etting out of
<u> </u>	Atte	tific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc. (- At home, farm, stree	et, factory, office	2	Bf. Location (Stre City or Town,	et and Number o	or Rural Route Nuvenic
2	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edical Cer	29a. Certifier (Check only 2 Medical Examiner: On the basis of ex	parkin ny knowledge, death amination and/or inve	occurred at the time estigation, in my opir	date and place, ar tion, death occurre	t. 106, nd due to the cau d at the time, date	Cambrid se(s) and manne and place, and	er as stated. due to the cause(s)
	roth within orth	Me	29b. Signature and title of certifier		29c. License r	number	290	I. Date signed (M	fonth, Day, Year)
	. >-0		▶ paranson		1400	59973		2/10/06	2
	7		29b. Signature and title of certifler 30. Name and address of person who completed cause of deat 31. Date filed (Month, Day, Year) APR 1 9 2006 32. Registrar's	h (Item 23a) (Type, P 0 Bramb.	Print) 10 St	Cambri	dge, M	0 21	613
	Sta Registr		APR 1 9 2006 32. Registrar's	Signature			,		

			1 - For State Registrar	State of Ma	aryland / Depa	artment of rtificate o			iene) 06	12667
1	Physici /Medic	_	1. Decedent's Name (First, Middle, Last) David Caius	Wilson				2 Date of Death	2, Day 2006 Year	3. Time of Death 5:03 PM м
	Examir		4a. Facility Name (If not institution, give st Kline Hospice H			4b. City, Town	n, or Location of Death Airy	1	4c. County of Death Freder	
	Funeral Director		210 09 3200 11	7. Age M 2□F	e (In yrs. last birthday) 86 Yrs.	If Under 1 Ye Months Da		8. Date of Birth Month, Day, Dec. 1.	2, 1919 9. Birth	place (State or Foreign aryland
	Maryland a-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Frederic	ek	10c. City, Town or Lo		<u> </u>			10d. Inside City Limits 1 ☐ Yes 2 X No
	h with the 23a or 28	al Director	10e. Street and Number 7069 Catalpa Ro	ad		10f. Zip Cod 217		10	Og. Citizen of What Cou	intry?
036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23e or 28e-f show say injury or other traumatic event. If a Medical Examination untilled at Ance.	by Funeral	11. Marital Status 1: 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent ! Armed Forces? 1/2 Yes 2 N If Yes, Give Year or Dates:	104.04.0 4.04.0	Was Decedent of the Yes, specify of the Yes 2 1 1 Yes 2 1	of Hispanic Origin? (Suban, Mexican, Puerl No <i>Specify:</i>	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White Specify: Wh	
Maryland 21215-0036	d within 72 ho giene. or then "natur the Medical	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)				cupation ne during most of woi irred) inting Off		US Govern	
yland	ould be file Mental Hy, arked oth	To Be C	17. Father's Name (First, Middle, Last) George Wash	ington Wi	ilson			ne (First, Middle, M e L. Fles		
, Mar	and 2 sho ealth and m 27 Is my		19a. Informant's Name/Relationship (<i>Typ</i> Mrs. Virginia A. W		ife 7069	9 Catal	oa Road, F	rederick,	City or Town, State, Zi Maryland	21703
Baltimore,	t. Pages 1 rtment of H rtant: If iter		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify) 21. Sign fure of Funeral Service Licenses			matory or other Memorial	Cardens Apri	1 18, 2006		own, State k, Maryland
Ba	permi Depa Impo eny ir		23a. Part1. Enter the disease, or complic	Gasford		106 East	and Basfor t Church S	t., Frede	erick, MD	21701
8760,	Physician /Medical Examiner but sician and but sician and site private site private site private site private site private site site site site site site site si	dicai Examiner	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a	a consequence of): a consequence of):	ongestiv	ve Heart F	ailure		Interval Between Onset and Death
O. Box 6	The law requires that the death certific the has been signed by the attending proage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death 3 ☐	∃Ectopic pregna ∃ Other (specify			23d. Date of delin	very Day Year
s, D	quires that n signed b uld be deta	by	Part II. Other significant conditions cont Chronic Obstruct				given in Part I.		acco use contribute to s 2 □ No 3 Pro	the cause of death? bably 4 Unknown
al Reco	: The law rec cate has bee , page 2 shor	Completed	Coronary Artery	Disease				24a. Was ar autopsy perform 1 Yes 2	prior to co	opsy findings available ompletion of cause of
Division of Vital Record	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	ospital: 1 Inpatie 28a. Date of Injur (Month, Day	y 28b. Time o (Year) Injury	f 28c. lr	Cther: 4 Nursing Finary at Nork?	28d. Describe ho	nce 6 XOther (Spec w injury occurred	√Hospice Hus
Ö	vital or At urs after d rel Direct lled in by		4 Homicide determined	1	ury - At home, farm, st. c. (Specify)			City or Town		
	To the Hospital within 24 hours a To the Funeral Completely filled in	Medical	29a. Certifier (Check only one) 1 (X Certifying Physic (Check only one) 2 → Medical Examination (Check only one) 1 (X Certifying Physic (Check one) 1 (X Certifying Physic (Check on	er: On the best of and manner sta	examination and/or in	vestigation, in m	e time, date and place by opinion, death occu ense number	irred at the time, da	use(s) and manner as the and place, and due od. Date signed (Month) April 13,	to the cause(s)
,	15		30. Name and address of person who con Ali J. Afrookteh	- //		Print)				
	Sta Regist		31. Date filed (Morith, Day, Year)	32. Registra	ar's Signature	and B				

			For State Registrar	State	of Marylai		irtment of F tificate of	lealth and I Death		giene)	6 1	2668
	231		Decedent's Name (First, Middle,	Last)					2. Date of Dea	ith		3. Time of Death
2	Physici /Medic		Delor	es A. V	Varner				April	16, 2	Υ _{θα} ς 006	1:56P M
	Examin	_	4a. Facility Name (If not institution,	give street and nu	ımber)		4b. City, Town, o	r Location of Death	1	4c. County	of Death	
		1967 J	Heritage Harb				Annapo	lis		Anne	Aru	ndel
4	Funeral		5. Social Security Number 217-32-2999	6. Sex 1 ☐ M 2 ဩ F	7. Age (In yrs	. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	1935	€o <i>u</i> n	lace (State or Foreign try)
Z,	Director		Usual Residence of Decedent	- A	70	113.			Nov. 2	, 1935	wasr	nington, DC
	/land		10a. State 10b. County		10c. C	ity, Town or Lo	cation				11	0d. Inside City Limits
	death with the Maryland ma 23e or 28a-f ehow Linual be notified at	to	Maryland Anne	Arunde	1 D	avidso	onville					1 ☐ Yes 2🏋 No
	h the	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of \	What Coun	try?
	th wit		1522 Manor V	iew Roa	d		210	035		USA		
,		Funeral	11. Marital Status	Armed F		J.S. 13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)		e - Americ	
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Ş	hour tural	a p	15. Decedent's	Year or I	Jates:	16a Decen	ent's Usual Occup	ation		16b. Kind of B		
Ċ	within 72 ene. than "ne:	plet	(Specify only highest	grade completed		(Give	kind of work done OO NOT use retired	during most of wor	king	TOD. KING OF D	331103371110	lustry
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	be filed stal Hygi of other event, I	Bec	17. Father's Name (First, Middle, L.					18. Mother's Nan	ne (First, Middle,	Maiden Suman	10)	
<u>ā</u>	should be nd Menta marked imatic ev	2	Irving R. Won	rley				Eve	lyn C.	Collin	s	
Maryland	2 sho and le mu	1 1	19a. Informant's Name/Relationshi			19b. Mailin	g Address (Street	and Number or Ru	ral Route Numbe	r, City or Town,	State, Zip	^{Code)} 21035
	s 1 and f Health Item 27 other tr		Brenton R. Wa	arner,		sband	1522 F	Manor V	iew Rd.	David	lsonv	ville,MD
Baltimore,	Pages 1 nent of H int: If Ite		20a. Method of Disposition 1 XBurial 2 Cremation	3 Removal from	1	cemetery cren	sition (Name of natory or other place Mom	Cardono	Date . 1/10/	20c. Location	,	mville, MD
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			23a. ant1. Enter the disease, or o shock, or heart failure. List o	nly one cause on	each line.	un. Do not ent	>		or respiratory an	631,		Interval Between Onset and Death
The state of	Physician /Medical		disease or condition resulting in death)	a	celkis		Diseces	<u>e</u>				
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Box	eath certifi attending for use as	Physician/Me	23b. Was decedent pregnant		utcome of pregr birth 2 Pet		Ectopic pregnancy	,			te of delive	·
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٦.	res that the de signed by the a be detached i	Phy	Part II. Other significant condition	S contributing to	death but not re	culting in the ur	adorhina cauca an	on in Part I	23e Did to	hacco use cont	ribute to th	e cause of death?
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Ö	w require been sign	etec	- Journa									,
Records,	The law cate has I page 2 s	Completed							24a. Was a autops perfor	sy	were autor prior to con death?	psy findings available npletion of cause of
									1 ☐ Yes	2.□No	1 ☐ Yes	2 □ No
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ö	Phys r this sral di	٦. ا	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date	of Injury	ER/Outpatien 28b. Time of	t 3 DOA 28c. Injur		ome 5 Residence 128d. Describe h			7
0	ding F th. : After s funer	tlor	1.☑Natural 5 ☐ Pending 2 ☐ Accident investiga	(Mo	nth, Day Year)	Injury		k? Yes 2 □ No				
Division of	l or Attendi after death. Director: A	ifica	3 Suicide 6 Could no 4 Homicide determin	1ed 280. Plac	e of Injury - At I	nome, farm, str	eet, factory, office		28f. Location (S		er or Rura	l Route Number,
á	s afte	Certification:	4 () Homicide	Dulle	ding, etc. (Spec	iry)			City or Tow	n, State)		
	ospit hour unere ly fille		29a. Certifier Check only 2 Medical E	Physician To It	ie best if my kn	owledga saatt	specimed at the tir	na date and slane	and due to the o	auso(s) and ma	incree et	ated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: Atter this certific completely filled in by the funeral director.	ledical	one)	and ma	nner stated.	ation and/or m		pinion, death occu				
	To T To T	Σ	29b. Signature and title of certifier	,			29c. Licens	e number	2	9d. Date signe	d (Month, L	Day, Year)
}	/						J D5	7028	3	041	171	06
	15	1	30. Name and address of person w	no completed cau	use of death (Ite	m 23a) (Type,	Adit	ya Chor	pra, MD	mi		1 & 1
		1		T 1 1 1 1 7	3 4 10 . M							1/ \ 1
	Sta	ļ.	31. Date filed (Month, Day, Year)	32	Registrar's Sign	lature	10011	minut	1011211		XI.	401

		1 - For State Registrar	State of Maryla		artment of F rtificate of			giene	16 12669
Physici		Decedent's Name (First, Middle, Lawrence		Neltmar	1		2. Date of De Month APRIL	Day 16, 200	Year 6 3. Time of Death 04:53 a.M
/Medio Examir		4a. Facility Name (If not institution, g Memorial Hospita	give street and number)		4b. City, Town, o			ALLE	ry of Death GANY
Funeral Director		5. Social Security Number 217-10-6282 Usuaf Residence of Decedent	. Sex 7. Age (In yr	s. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bir Month, Da Jul 22	, 1917	9. Birthplace (State or Foreign Country)
e Maryland Sa-f show	ctor	10a. State 10b. County Alleg		City, Town or Lo Cumb	perland				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
eth with th	Funeral Director	10e. Street and Number 229 Baltimore Av				21502			SA
is 1 and 2 should be filed within 72 hours after deeth with the Maryland of health and Mental Hygiene. Item 27 is marked other than "neturel", or items 23s or 28s-f show other traumatic event, the Medical Examinations and its modified at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: WW		Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2 No	Hispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No to Rican, etc.)		ice - American Indian, ack, White, etc. ^{(fy:} white
hin 72 ho 9. In "netur Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+)	16a. Deced (Give life.	ient's Usual Occup kind of work done DO NOT use retire	pation during most of world)	rking	16b. Kind of B	Business/Industry
be filed with tat Hygiene. d other than	Be Corr	12 17. Father's Name (First, Middle, La	st)	Sewag	je Treatm	18. Mother's Nar	ne (First, Middle	, Maiden Sumar	•
2 should be filed v and Mental Hygie Is marked other t	2	George W. We	(Type, Print)			and Number or Ru		er, City or Town	, State, Zip Code)
Peges 1 and 3 hent of Health int; if Item 27 iny or other tr		Jean Byrne 20a. Method of Disposition 1	Linemovariioni State	. Place of Dispo cemetery, cren	sition (Name of natory or other pla		Date		MD 21502 - City or Town, State
permit. Peges 1 an Department of Heal Important; If Item 2 any Injury or other		4 □ Donation 5 □ Other (Spe 21. Signature of Furieral Service Lic	City)		morial Park Name and Addre	iss of Facility Ili Funeral H	4/20/2006 Iome, PA	Cumbe	erland MD
Physician /Medical Examiner		23a. Part 1. Enter the disease, or or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	mplications that caused the delivious cause on each line. a. Renal For Due to (or as a consider of the consider of the consider of the consider of the consider of the consider of the consider of the consider of the consider of the consider of the consider of the consider of the consider of the consider of the consider of the consider of the consider of the consider of the consideration of the considerati	ailure equence of):	er the mode of dyir	ginia Avenung, such as cardiac	or respiratory a	rland, MD	Approximate Interval Between Onset and Death
Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and rail director, page 2 should be detached for use as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a const	equi nce of):					1 Week
To the Hospital or Attanding Physician: The law requires that the death certific within 24 hours effer death. To the Funeral Director: Affer this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1☐Live birth 2 ☐Fe 4☐ Pregnant at time of 9☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)	у			ate of delivery onth Day Year
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The law recate has bee	Completed						24a. Was auto perfo 1 Yes	psy prmed?	Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
ysician ysician is certifi director	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospitaf: 1 Inpatient 2	☐ ER/Outpatien	t 3 DOA Oth	200	ath <i>Check only o</i> lome 5 ☐ Resi		her (Specify)
ath. r: After the funeral	ation: T	27. Manner of Death 1 Naturaf 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	nyat rk?]Yes 2 ☐ No	28d. Describe	how injury occur	rred
Office of the Hospital or Attanding within 24 hours elter death. To the Funeral Director: Affeit completely filled in by the fune to the funeral process.	Certification:	3 Suicide 6 Could no 4 Homicide determina		home, farm, str cify)	eet, factory, office		28f. Location (. City or To	Street and Numb wn, State)	ber or Rural Route Number,
ne Hospi n 24 hour ne Funer detely fill	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of my k aminer: On the basis of exami and manner stated.	nowledge, death nation and/or inv	n occurred at the til vestigation, in my o	me, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and madate and place,	anner as stated. and due to the cause(s)
To the within com	×	29b. Signature and title of certifier	B		29c. Licens			April	7 , 2006
(Ç	ate_	30. Name and a ress of person with the stress nad Johnso	n Heig	hts Me	d. Bld	g, Cum	berlan	nd, MD 21502	
Regist	rar	APR 2 1	2006 Heave	K G	occide o				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** landolph wing and aco April 4, 2006 8:10 A. /Medical 4a. Facility Name (II not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 2520 Waterside Drive Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**M**M 2□ F 273-36-2194 66 Director May 25, 1939 Ohio Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. Count ir than "naturel", or items 23a or 28a-f ehow The Madical Examiner must be notified at 10d. Inside City Limits Frederick Frederick Maryland Director 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 21701 10g. Citizen of What Country? 2520 Waterside Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian 1 Tes 2 No 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify Š white 3 ☐ Widowed 4 ☐ Divorced "naturel", Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Sales Mobile Homes permit. Pages 1 and 2 should be filed Department of Heelth and Mental Hyg Important: if Item 27 is marked other eny Injury or other traumatic event, I 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Randolph Winegardner Florence Ames 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Winegardner 2520 Waterside Drive, Frederick, Maryland 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Shiffler Cemetery 4-9-2006 Bryan, Ohio 21. Signature of Funeral Service Ocensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike. Frederick, Maryland 21702 aron ane 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Colon Cy extensive /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, It any, I sawing to him ordinate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): g physicien and as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): by Physician/Medical use as t the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No be detached for Month Year Day 5 Other (specify) signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? as been signal Be Completed 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificete has autopsy performed? page 1 Yes 1 ☐ Yes 2 ☐ No 26 No Physician: funeral director. 25. Was case referred to medical 26. Place of Death Check only one examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 ☐ Pending investigation To the Hospital or within 24 hours after death.
To the Funerel Director: Aft 1 Natural М 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge ideath occurred at the time, date and place, and due to the dates(s) and mainer as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only

Registrar

State

29b. Signature and title of certifier

31. Date filed (Month, Day APR

30. Name and address operson who completed cause of death (Item 23a) (Type, Print) 200305

7 2006

mp

gistrar's Signature

29c. License number DIYLZC 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760,

			- FOI	partment of Health and Me Pertificate of Death	ental Hygier	2000 12011
	Physicia	Ages 1	1. Decedent's Name (First, Middle, Last)	2	Date of Death Month	Day Year 3. Time of Death
	/Medic	al	Harold Ray Williard			2006 9:05 P 4c. County of Death
	Examin	er	4a. Facility Name (If not institution, give street and number) Homewood at Crumland Farms	4b. City, Town, or Location of Death Frederick		
-	E	*	5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	ay) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Frederick 9. Birthplace (State or Foreign Country)
	Funeral Director		220-16-2062 1⊠M 2□F 80 Yr.	Months Days Hours Min.	(Month, Day, Yell une 5,19)	
	pu ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of			10d. Inside City Limits
	show	-				1 ▼ Yes 2 No
	the M	ecto	Maryland Frederick Thurmon	10f. Zip Code	100	Citizen of What Country?
	with 3g or	Funeral Director	4 Clarke Avenue	21788		USA
	death ms 2;	nera		13. Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ri	ify Yes or No-	14. Race - American Indian, Black, White, etc.
ဖွ	after or ite	Ful	1 Never Married 2 Married 1 Yes 2 No If Yes, Give	1 ☐ Yes 2 No Specify:	ican, etc.)	Specify: White
21215-0036	within 72 hours after death with the Maryland ene. than "neture!', or Items 23s or 28a-f show the McJicel Examiret must be mullis of an	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		1.00	
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72	withii iene. • than	dwo	Elementary/Secondary (0-12) College (1-4or 5+) 12 Ins	urance Sales Manager	/Agent 1	Incurance Sales
פַ	il Hygir other vent, I	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (
/lar	should be ind Mental s marked c umatic ev	ToE	Unknown	M. Julia	a Sharer	
Maryland	C/ C/ 0		,,,,,	ailing Address (Street and Number or Rural i		
	1 and Health em 27 ther tr			Clarke Avenue, Thurmo		. Location - City or Town, State
altimore,	Pages hent of Hunt: If ite		1 Ruriol 2 Cremation 3 Removal from State cemetery,	ven Mem. Gards 4/8/20		ederick, MD
ΙĦ	urtmer ortant injury		* 4 □Donation 5 □Other (Specify) Resthat 21. Signature of Funeral Service Licensee	22. Name and Address of Facility Stau		
Ba	Depar Depar Impor eny ir		23a. Part 1. Soler the disease, of complications that caused the death. Do not	104 E. Main street,	Thurmont	, MD 21788
8760,	be attending physician and burial-transit as the burial-transit	cal Examiner	shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of)	Myorardial 3 rosefrestic He	entari entt)	Approximate Interval Between Onset and Death Onset Approximate Interval Between Onset and Death Onset Approximate Interval Between Onset Approximate Interval Between Onset Approximate Interval Between Onset Approximate Interval Between Onset Approximate Interval Between Onset Approximate Interval Between Onset Approximate Interval Between Onset Approximate Interval Between Onset Approximate Interval Between Onset Approximate Interval Between Onset Approximate Interval Between Onset Approximate Interval Between Onset Approximate Interval Between Onset Approximate Interval Between Onset Approximate Interval Between Onset Approximate Interval Between Interval Betw
.O. Box 6	that the death certifica led by the attending ph detached for use as th	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
<u>a</u>	8 50	by	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
Vital Records,	w require been si should I	Completed	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		24a. Was an	24b. Were autopsy findings available
Rec	The lav	du	DIA VETES MANIENT AVETE		autopsy performed	prior to completion of cause of death?
a		ပိ	25. Was case referred to medical	26. Place of Death (No 1 ☐ Yes 2 ☐ No
	G S	ToB	examiner? 1 Yes Hospital: 1 Inpatient 2 ER/Outp.	atient 3 DOA Other Nursing Home	e 5 Residence	6 ☐Other (Specify)
n of	ng Ph Iter th		27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tin (Month, Day Year)	ry Work?	3d. Describe how in	njury occurred
Sio	tendii leath. tor: A the fu	catl	2 Accident investigation	M 1 Yes 2 No	Pf Location /Street	and Number or Rural Route Number,
Division	or Ati	ertification:	3 Suicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	City or Town, St	
J	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical Ce	29a. Certifier Certifying Physician: To the best of my knowledge, of (Check only 2 Medical Examiner: On the basis of examination and/	eath occurred at the time, date and place, an or investigation, in my opinion, death occurred	nd due to the cause d at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the within 2 to the Complet	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
	F 2 5 8		D (And da / / A	MDD16428		HITIDL
			30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Pfint)		113100
			Casper Clime 300 West Ninth Stre	et, Frederick, MD 217	701	1
	Sta Registi		31. Date filed (Month, Day, Year) APR 0 7 2006 32. Fegistrar's Signature			

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State of Maryland / Department of Health and Mental Hygiene[] [] [Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Year Greenberg Myrna Wilensky 3, April 2006 /Medical 11:40 A. 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner The Casev House Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Feb. 7, **Funeral** Birthplace (State or Foreign
Country) Months 1□M 2₩F 047 - 32 - 051364 **Director** Montgomery Usual Residence of Decedent the Maryland 10c. City, Town or Location or 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at 1√2 Yes 2 □ No Maryland Silver Spring Montgomery Direct 10e. Street and Number 10g. Citizen of What Country? 2900 N. Leisure World Blvd., # 510 238 20906 U. S. A. death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married □Yes 2 No o, Baltimore, Maryland 21215-0036 Yes Give 1 ☐ Yes 21 No Specify: þ Specify: 3 Widowed 4 Divorced White Year or Dates: "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Homemaker Own Home 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Surname) Louis Greenberg Toby Olmer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2900 N. Leisure World Blvd., # 510, Silver Spring, Maryland 20906 19a. Informant's Name/Relationship (Type, Print) Julius "Ted" Wilensky-Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beth Israel Cemetery 4-5-2006 New Haven, Connecticut 21. Signature of Funeral Service Licenses Danzansky-Goldberg Memorial Chapels, Inc. Donald (1170 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused the feath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Renal Cell Carcinoma **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions. It any localing to in a class cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Month Day Year 5 Other (specify) ed by the a 9□ Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Tyes 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No Division of Vital 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence & Other (Specify) Hospice 1 ☐ Yes 2 🔀 No Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 2 ☐ Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examination On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) \sim D D35635 April 4, 2006 30. Name and address of person oc completed cause of death (Item 23a) (Type, Print) Dr. Joseph Kaplan 18111 Prince Philip Drive, Suite 100, Olney, Maryland Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

0 6 2006

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	Certificate of Death		Reg. No.	Ü	160	10
V	Dhoola	ş 4	Decedent's Name (First, Middle, Last)		2. Date of De	ath	V	3. Time of	Death
	Physici /Medic		Henrietta S. Walker		April	4 , 200	6	4:28	Рм
2	Examir	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County			
		1	Washington Adventist Hospital			Mont			
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 XF 7. Age (In yrs. last birthe 85 Yr	day) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Bir (Month, Da Iay 23	th ly, Year) 1920	9. Birthpl Count Wash	ace (State or try) D.0	Foreign C •
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of	or Location			10	d. Inside Cit	v Limits
	Many -1 sh Fied s	jo	D.C. N/A Washir	ngton				1 🔀 Yes	
	r 28a	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of W	hat Count	try?	
	72 hours after death with the Maryland "naturs!", or Items 23a or 28a-f show Olcal Examinar must be notified at	aD	1367 Parkwood Place, N.W.	20010		United	Stat	ies	
	ems erms	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No		- America		
36	or li	by Fu	1 Never Married 2 Married 1 Yes 2 No If Yes, Give	1 ☐ Yes 2 No Specify:			Bla		
2-0036	hour	ed b	3 ☑ Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. D	ecedent's Usual Occupation					
212	≐ . c ⋅€	Completed	(Specify only highest grade completed) ((Give kind of work done during most of work fe. DO NOT use retired)	ng	16b. Kind of Bus	siness/ind	ustry	
7.7	filed within Hygiene. ther then " int, the Max	E O	Elementary/Secondary (0-12) College (1-4or 5+) Ho	omemaker		Domes	stic		
<u> </u>	be filed tal Hygid d other event, il	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle,	Maiden Surname)		
<u>a</u>	5 g & c	.0	James Short	Henrie	tta Da	У			
Maryland	2 shc and Is ma		19a. Informant's Name/Relationship (Type, Print) God – 19b. N	failing Address (Street and Number or Rura				Code)	
<u>ح</u> ش	and fealth im 27 har tu		Sonya D. Baggett/ daughter 40	007 Oglethorpe S				20782	
Baltimore,	or of		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of D cemetery,	crematory or other place)	Date	20c. Location - 0	•		
	rtmer rtant njury		4 Donation 5 Other (Specify)	incoln Cem. 4/8,		Brentwo	od,	MD	
g	permit. Pages 1 and 2 shou Department of Health and M Important: If Item 27 Is mar sny Injury or other traumat QDE.		21. Signature of Funeral Service Licensee	22. Name and Address of FacilitMcG1	ire F	uneral	Serv	vice	0010
176	As a		23a. Part1. Enter the disease, or complications that caused the death. Do not	7400 Georgia Ave				Approximate	
	Physician		Immediate Cause (Final	1 /	. roop. a.o. y a.	7031,	1	Interval Betw Onset and De	een
<i>Y</i> .	/Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	Deck					
	Examiner		Do on sha	(), 0 - 0 - 1					
	D =	ner	Sequentially list conditions, if any leading to in module cause. Enter Underlying						
	ecute and trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of)						
Š,	be ex cian a		Due to (or as a consequence of):						Y
09/89	certificate be executed iding physician and ise as the burial-transit	/Medical	d				1000	-	
×	certifi iding	/We	IF FEMALE: 23h Was decedent pregnant 23c. If yes, outcome of pregnancy			- W	-		
ñ	death e atter	clar		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date Mont		y Day Ye	ar
į	w requires that the death observing the attenshould be detached for u	Physician	9 ☐ Unknown 9 ☐ Unknown	one (specify)					
L L	The law requires that the the has been signed by the bage 2 should be detached.	by P	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did to	bacco use contrib	oute to the	cause of de	ath?
ecoras,	equire en sig		Dendre		1 🗆 Y	es 210 No 3	Probai	bly 4 □Un	iknown
ပ္	K2 55 ED	plet	Corobsevasula Accio	Let.	24a. Was		ere autops	sy findings av	/ailable
		Completed				med? de	ior to comp ath? Yes 2	piletion of cau :□ No	use of
	ysician: The I	Be (25. Was case referred to medical examiner?	26. Place of Death	517 79.5		1103 2		
5	or Attanding Physician: ifter death. Director: After this certific in by the funeral director,	မ	1 ☐ Yes 2 🖫 No Hospital: 1 → npatient 2 ☐ ER/Outpa	itient 3 DOA Other: 4 Nursing Hor	ne 5 ☐ Resid	ence 6 Other	(Specify)		
	After Uner	on:	27. Manner of Death 28a. Date of Injury (Month, Day Year) 1 ↑ Natural 5 □ Pending 28b. Tim Injury	e of 28c. Injury at 28c. Work?	8d. Describe h	ow injury occurred	d		
UNISION	death ctor: / the	lcat	2 Accident investigation 3 Suicide 6 Could not be 280 Blace of Injury At home from	M 1 Yes 2 No	104 1	N			
<u> </u>	after Direction by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	City or Tow	itreet and Number in, State)	or Hural I	Houte Numbe	3r,
	spita nours neral		29a. Certifier 1 Decertifying Physician: To the best of my knowledge, do	eath occurred at the time, date and place, a	and due to the o	allse/s) and man	ner as stat	tad.	
	To the Mospital or Attanding Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral or	edical	(Check only ane) 2 Medical Examiner: On the basis of examination and/o and manner stated.	r investigation, in my opinion, death occurre	ed at the time, o	date and place, an	d due to ti	he cause(s)	,
	To the within To the Comp	M	29b. Signature and title of certifier	29c. License number	ž	29d. Date signed (Month, Da	ау, Үөаг)	
	1		The Sign	1)45666		4-5-	06		
)		3 . Tame and ad ress of person who completed cause of deal (Item 23a) (Ty	pe, Print) Dpinder Singh,	MD		M	0 2	2/0
2.4	1	40	19000, 670000	ex un, 120	1 00	10416	,	1 0	-4,
	Star Registra		31. Date filed (Month, Day, Year) APR 0 6 2006	Special Control					
17.5		, 45°	, , , , , , , , , , , , , , , , , , ,						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 3 I Helen P. Weatherford 2006 March 7:05P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heritage Harbour Health & Rehab Annapolis Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept | 10 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex 9. Birthplace (State or Foreign **Funeral** 1925 Maryland 1 M XX 80 yrs. 220-16-7369 Director Usual Residence of Decedent with the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f ehow the Medical Examiner must be notified at MYes 2 No Maryland Anne Arundel Annapolis Direct 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 3542 Cohasset Ave 21403 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: Specify: Black ģ XXWidowed 4 □ Divorced "naturai", Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Anne Arundel Co. Elementary/Secondary (0-12) College (1-4or 5+) Secretary Board of Education 12 should be filed w h and Mental Hygier 7 is marked other th <u>2yrs</u> 12thother traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James H. Pindell Sr. Katherine Isaacs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Heelth and Important: If Item 27 is m any injury or other traum once. James Pindell(Brother) 113 Domino Rd. Annapolis, Md. 21401 20b. Place of Disposition (Name of Hicemotory) completely or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal Irom State 4-7-06 Memorial Gardens Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Wm. Reese & Sons Mortuary, Larry . Teese MOOY83 821 West St. Annapolis, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** accusema disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ol): Examine attending physicien and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No sete hes been signed by the page 2 should be detached 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? چ ltrue 70 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1/0503 this certificete hes 1 ☐ Yes 2 ☐ No funeral director, 25. Was case relerred to medical Be 26. Place of Death (Check only one examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Natural 2 Accident 5 Pending 24 hours efter death. Funerel Director: At 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Thomicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie Medical within 2 To the 29b. Signal e and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) 30. Name and address of person who completed cause of death (Item 23a) (Tyge, Print) 31. Date filed (Month, Day Year) APR 0 4 2006 State Registrar

State of Maryland / Department of Health and Mental Hygiene,

3. Time of Death

3:02 P M

1 Yes 2 No

Approximate Interval Between Onset and Death

Day

Year

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 05

32. Degistrar's Signature

			1 - For State Registrar	State of M	aryland	•	artment <i>tificate</i>			nd M		giene Reg. No.	006	100	12676
	Di		1. Decedent's Name (First, Middle, Last)		_						2. Date of Dea Month	ith Day	Ye	er	3. Time of Death
	Physici: /Medic		Harold Lee	Wel	ls						April	2,	2006		1800 M
7	Examin		4a. Fecility Name (If not institution, give s 7772 Pittsville		r)		4b. City. T		ocation of			4c.	Wicon)
B	Funeral Director		5. Social Security Number 6. Sex 214–34–9123	M 2□F 7. A	ge (In yrs. Ia	ast birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day 4/11/1	h /. Yeer) 935	9.	Birthpla Countr Mar	nce (State or Foreign y) yland
	p .		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	cation							10	d. Inside City Limits
	taryla shov	ō	Maryland Wicomico			Pittsv								100	1 Yes X No
	28a-1	Directo	10e. Street and Number			LICCDV	10f. Zip (Code				10g. Citia	zen of What	Countr	ry?
	h with		7772 Pittsville	Road			2.	1850				Ţ	JSA		
	deall sms 2	Funeral	11. Marital Status	2. Was Deceden Armed Forces	t Ever in U.S	S. 13. V	Vas Decede f Yes, specif	ent of His	panic Orig	jin? (Spec	cify Yes or No-	. 1	4. Race - A Black, V		
20	or it	by Fu	1 Never Married 2 Married	1 ☑ Yes 2 ☐ If Yes, Give △ Year or Dates	irFor	ce	☐Yes 2		Specify:				Specify:	whi	
Ş	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ont, it is Madical Examiner must be notified a	ed b	3 ☐ Widowed 4X Divorced 15. Decedent's Educ		: -		ient's Usual	Occupat	ion			16h Kir	nd of Busine	ass/Indi	istry
<u>.</u>	in 72	Completed	(Specify only highest grade Elementary/Secondary (0-12)		(5.1)	(Give life. L	kind of work OO NOT use	done du retired)	ring most	of workin	g				2011 9
212	d with giene er tha	mo	Elementary/Secondary (0-12)	1	3+)	Off	icer					US I	Milita	ary	
Maryland 21215-0036	0 d - >	To Be (17. Father's Name (First, Middle, Last) George William We	lls							(First, Middle, Cabe	Maiden	Sumame)		
Mary	es 1 and 2 should b of Heath and Ment I Item 27 is marked r other traumatic e		19a. Informant's Name/Relationship (Ty) David B. Wells/son								Route Numbe			e, Zip C	Code)
altimore,	of Health of Health f Item 27		20a. Method of Disposition			lace of Disposemetery, crem	sition (Name	e of her place	, 1	Di	ate	20c. Lo	cation - City	or Tow	m, Stete
E	Pages nent of i		1 XBurial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	moval from Stat	0	tsvil	-		1	4/7/0	06	Pit	tsvil	le,	MD
Balt	permit. Pages Department of Important: If It any injury or o		21. Signature of Funeral Service Liver Se	00				-			ome Pro Salisb				sociation 4
10.00			23a. Fert1 Enter the disease, or compli- shock, or heart failure. List only on	cations that cause e cause on each	the death									1	Approximate Interval Between Onset and Death
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E	/Medical Examiner			Due to (or a	s a consequ	uence of):									
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	cuted nd ransit	Examiner	that initiated events												
ő,	cate be executed obysician and the burial-transit	I Ex	resulting in death) Last	Due to (or a	s a consequ	uence of):								- 10	
8760,	physic physic the b	dlcai													
9 X	eath certific attending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcom	e of pregnar	ncy						2	3d. Date of	deliver	v
Box	death a atter d for u	iclar	in the past 12 months?	1☐Live birth 4☐Pregnant			Ectopic pre Other (spe					U	Month		Day Year
о. О	that the de ed by the detached	hys	9 Unknown	9□ Unknown											
	8 6 9	by	Part II. Other significant conditions con	tributing to death	but not resu	ulting in the ur	nderlying car	use giver	n in Part I.						cause of death?
COL	w requir been si should	Completed									24a. Wasa	an	24b. Were	autop	sy findings available
Re	he lav	dwo									autop	med?	prior	to com	pletion of cause of
ta	iclan: Th certificate rector, pag	0	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes (Check only or	2 □ No ne)	, ,	Yes 2	: NO
>	Physiclan: r this certifica ral director, i	To B	examiner? 1 Dres 2 No	ospital: 1 ☐ Inpa	tient 2 🗆 I	ER/Outpatien	t 3 DOA	Other	. 4 🗆 Nur	sing Hom	ne 5 A Resid	lence 6	Other (5	Specify)	
o uo	ding Afte fune		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of In (Month, D	jury Jay Yeer)	28b. Time of Injury	28 M	c. Injury Work	at ? es 2 □ N	145	8d. Describe h	ow injury	occurred		
Division of Vital Records,	or At fter o Sirec in by	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of I building,	njury - At ho etc. <i>(Specif</i> y	me, farm, stre	eet, factory.	office	=	2	8f. Location (S City or Tow	itreet and m, State)	d Number o	r Rural	Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 Certifying Physic (Check only one)	ician: To the bester: On the basis and manner:	of examinat	wiedge, death tion and/or inv	n occurred a vestigation, i	t the time	, date and nion, deat	d place, a h occurre	nd due to the o	ause(s)	and manne place, and	r as sta due to !	ted. the cause(s)
	o the o the omple	Med	29b. Signature and title of certifier	and manner:	stated.		29c.	License	number		- 2	29d. Date	a signed (M	onth, D	ay, Year)
)	+ ¥ + 20		In Su					1+5	049	>		4/5	706		
	SA		30. Name and address of person who co	mpleted cause of	death (Item	23a) (Type,	Print)								
_	12/2		Chris Sunder DAME	100 E CC	erroll S	7 50	ilista	7 4	N S	1180	i				
	Sta Registi		Chris Smd DME 31. Date filed (Month, Day, Year) APR 0 6 21	32. Redis	trar's Signal	ture	(H								
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		1 - For State Registrar	State of Marylan	d / Department of Certificate of			4000	12677
		Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of	Dealli	2. Date of Death	. No.	3. Time of Death
	sician edical	Paulline F	. Webs	ter		Month	Day 200	0750
	niner	4a. Facility Name (If not institution, give s			or Location of Death		4c. County of Dea	
			Nursing		MISPUY	4	Wicor	11100
Funer Direct		5. Social Security Number 76. Sex 220 - 10-96441	7. Age (In yrs.	last birthday) If Under 1 Yea Months Day		8. Date of Birth (Month, Day, Y	9. Bir	thplace (State or Foreign buntry)
pur *		Usuat Residence of Decedent 10a. State 1 10b. County	10c Cit	y, Town or Location				10d. Inside City Limits
e Maryla e-f ehov	ctor	AACILLA	nico	Salisbu	ury			X Yes 2 No
ING Z I Z I 3-UU30 De filed within 72 hours after death with the Maryland lal Hygiene. In the Hygiene of the rest in the manual of the the manual call be restitled as event. It as Medical Experience of the restitled as	Funeral Director	10e. Street and Number	s Sauhu	10f. Zip Code	1801	10g	Citizen of What Co	ountry?
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OUSO hours after tural, or its	by Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 Yes, specify Co		Hican, etc.)	Black, Whit	ie, etc.
2 hou	ted	15. Decedent's Educ	ation	16a. Decedent's Usual Occ	upation	16	b. Kind of Business	/Industry
Z I Z I D- d within 72 piene. rthen "ne	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retii		,g		
filed w Hygier other th	S	10	-	Nursing Admir		(57)	Health C	are
d be fits ental Hy cod oth	9	17. Father's Name (First, Middle, Last) James R. Vance			18. Mother's Name Dora Wa	,	iden Sumame)	
	2	19a, Informant's Name/Relationship (Ty)	no Print)	19b. Mailing Address (Street			She as Tours State	7i- Codol
Magary Tree tree		Walter J. Webster,			r., Salisb			zip Code)
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ury ent		' 4 ☐ Donation 5 ☐ Other (Specify)		ringhfill Mellor ardens			Hebron, M	
Definit. Pa	SUCE.	21. Signature of Funeral Service License	lo-	Holloway 501 Snow	Funeral H Hill Rd.,	ome Profe Salisbu	essional a	Association 804
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/Medic Examin		resulting in death)	Due to (or as a consequ	uence of):				
LAdmin		Sequentially list conditions,	Due to (or as a consequ	uance of				
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axecu and al-trai	Examiner	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):				
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ath cer atth cer titlendir or use	an/A	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		cy		23d. Date of de	,
. 0 00	by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of de 9☐ Unknown	eath 5 Other (specify)	<u></u>		Month	Day Year
	d >	Part II. Other significant conditions con	tributing to death but not resu	ulting in the underlying cause of	given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
ecords, F.O. law requires that the as been signed by th 2 should be detache						1 🗆 Yes	2 0 No 3 P	obably 4 Unknown
	Completed					24a. Was an	24b. Were au	topsy findings available
E	E O					autopsy performe 1 Yes 2	d? death?	completion of cause of
ysician: T ysician: T is certificat director, pi	Be	25. Was case referred to medical			26. Place of Death			
_ × E			ospital: 1 Inpatient 2	ER/Outpatient 3□ DOA C	ther: 4 Nursing Hon	ne 5 🗆 Residend	e 6 Other (Spe	cify)
ng Ph Miter th Mer al	on:		28a. Date of Injury (Month, Day Year)	28b. Time of Injury 28c. Injury W		8d. Describe how	injury occurred	
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DIVISION all or Attending s after death. If Director: Afte	Certification:	4 Homicide determined	building, etc. (Specify	ome, farm, street, factory, office y)	a (4	City or Town, S	et and Number or Ru State)	urai Houte Number,
UIVISION O To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical		ician: To the best of my kno- ter: On the basis of examinat and manner stated.	wledge, death occurred at the tion and/or investigation, in my	time, date and place, a opinion, death occurre	nd due to the caused at the time, date	se(s) and manner as and place, and due	s stated. to the cause(s)
To the within 2 To the Complet	Mec	29b. Signature and title of certifier	und mainter stated.	29c. Licer	nse number	29d.	Date signed (Mont	h, Day, Year)
8 4 € 4	W	1 /300	1.D	D	57951		4/6/20	01
18	4	30. Name and address of person who co	mpleted cause of death (Item				14.1-	(2)
1		Dr. Babulal	Das 100	Multora S	t. Salis	DULYI	MU U	804
	State	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture				

State of Maryland / Department of Health and Mental Hygiene State
Registrar Amended item #5 per fh/wich@frtificate of Death 04-13-2006 Reg. No. dls 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 4 Day 4 **Physician** 1118 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NICOMICO Medical 5. Social Security Number 215–20–4458 ff Under 1 Year | If Under 4 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1□M 2×F Days Hours Director Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location 10d. fnside City Limits ● how item 27 is marked other then "natural", or itema 23a or 28a-f ebor other traumatic event, it a Medical Examinar must be notified at Ves 2 No 100 MICO Director DAUSBURV 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? SA 21801 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritaf Status Black, White, etc filed within 72 hours after Hygiene. Yes ZX No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□ Yes 2XNo Specify: þ Specify: BLACK 3 Widowed 4 □ Divorced Year or Dates 16b. Kind of Business/Industry W (CDM)CD Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DUNTY Elementary/Secondary (0-12) College (1-4or 5+) EDUCATION) 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental MARY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Jural Route Number, City or Town, State, Zip Code) 12-MANDA ALISBURI WILLIAM KELLE 20a. Method of Disposition BROTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location City or Town, State Pages 1 Department of the important: If its any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) ID 106 21. Signature of Funeral Service Licenses Name and Address of Facility BENNIE SMITH SABELLAST, SALISBURY, MD. 2180, Approximate fnterval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. fmmediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner cate hes been signed by the ettending physicien and page 2 should be detached for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Ar 1 Yes 2 No 3 Probably 4 Unknown Be Completed After this certificate has been Pin 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed HM 2 🗆 No 1 Tes 2 No 1 Yes To the Hospital or Attending Physicien: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 des 2 No ဥ 1 Inpatient 2 Pr/Outpatient 3 DOA 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. fnjury at Work? 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deat To the Funeral Diractor: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SNG 100 E. 31. Date fifed (Month, Day, Year) State APR 0 7 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death cedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Visher 1030aM 06 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner OALISBURY der 1 Year | If Under 24 Hrs. | WICDMICT HOSPIC If Under 1 Year Months Days Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Min. 1**X** M 2□ F Hours Director 220-12-025 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow injury or other traumetic avent, the Medical Examinar must be notified at 1 Yes 2 No Director MD 100mico DALISBURL 10e. Street and Number 10g. Citizen of What Country? or items 23s JSA Funeral VE Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ Yo Specify: Specify: BLACK Be Completed by 3 Widowed 4 Divorced "netural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) Coflege (1-4or 5+) KEGIDWA permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Itam 27 is marked other properation of other traumatic event page. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ISHER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SALISBURY Date 200. Locati 12-11/AN WILLIAM KELLEY-BROTHER-IN-LAW MD Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 10/06 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BENDIE Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. fmmediate Cause (Final disease or condition resulting in death) **Physician** one month /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attanding Physician: The law requires that the death certificate be executed sate has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Medical Certification; To Be Completed by Physician/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 🗆 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes Impatient No No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Alter Natural 2 Accident 5 Pending 1 Yes 2 No within 24 hours after death. To the Funeral Director: A investigation completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (from 23a) (Type, Print) 31. Date filed (Month, Day, Year) State APR 0 7 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiena A 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year Young 11:24 AM 9 2006 April 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death 105 Dahi JOHUS If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1 M 2 F Yrs 213-14-6978 Usual Residence of Decedent 81 10-14-1924 Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Hurlock Maryland Dorchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21643 **USA** 4210 East New Market Hurlock Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No 3 Widowed 4 □ Divorced Black. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Press Operator Sewing Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Henry Young Ida Farrare 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ralph B. Young 4210 East New Market Hurlock Rd., Hurlock, Md. 21643 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State □ Donation 5 □ Other (Specify) East New Market Cem. 04-15-06 East New Market, Md. 22. Name and Address of Facility Bennie Smith Funeral Home 21. Signature Funeral Service Licerses 516 S.Main Street, Hurlock, Maryland 21643 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hemorrhagic Shock hours disease or condition resulting in death) Due to (or as a consequence of) Due to or as a consequence of): Acris hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):

permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic excession. Pnysician /Medical Examiner

the attending physician

certificate has

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice

24 hours a

within 2 To the

2

certificate be executed

Box 68760

P.O.

Division of Vital Records.

Physician

/Medical

Examiner

10a State

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28a-f show

Director

Completed by Funeral

traumatic event, the Medical Examinatinust be notified at

the Maryland

with t 5 items 23a death

> Examiner use as the burial-transit Physician/Medical ð Completed

IE FEMALE 23b. Was decedent pregnant 25. Was case referred to medical

examiner

1 Natural

2 Accident

3 Suicide

4 Homicide

29b. Signature and title of certifier

1 ☐ Yes 2 🔀 No

27. Manner of Death

in the past 12 months?
1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death

4 Pregnant at time of death

3 ☐ Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Nnknown

24a. Was an 2 No 1 Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

2006

Year

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Tyes 2 No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA

29a, Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated

141)

Hospital:

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

Res - 000

29d. Date signed (Month, Day, Year)

21287-9106

April

MD

30. Name and address of person who sor pleted cause of death (Item 23a) (Type, Print)

Welle Street North Joza 32. Registrar's Signature 31. Date filed (Month, Day, Year) APR 1 2 2006

Baltimon

DHMH 17 Rev 1/200

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 14, Day 2006 **Physician** Robert A. Anderson 7:15 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3900 Old Crain Hwy Prince George's Upper Marlboro If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1**X**XM 2□ F 043 24 1083 74 Yrs. Director April 26, 1931 New Haven, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director 1 Yes 2 Tyte Maryland| Prince George's Upper Marlboro 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3900 Old Crain Hwy 20772 United States or Itame 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1V Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married X2X Married 1 ☐ Yes 2 ☐XNO Specify: ð Specify: 3 Widowed 4 Divorced White Year or Dates 'natural' Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Electric Engineer Central Intelligence other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Ie marked other you or other treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Valdimar Anderson Olive Burbaum ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara S. Anderson (Wife) 3900 Old Crain Hwy, Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cometery, crematory or other place) April 24, 2006 20a. Method of Disposition 1XXBurial 2 Cremation 3 Removal from State Cheltenham, Maryland Maryland Veterans Cemetery 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 70015 wh Alexandria Ferry Road, Clinton, MD lik 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ROSTATE CARCINOMA **Physician** ear disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of). Physician/Medical as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of defivery 3 Ectopic pregnancy ŏ Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 8 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No Hospital or Attending Physicien: Be 25. Was case referred to medicat examiner? 26. Pface of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home Sp Residence 6 Other (Specify)
Injury at 28d. Describe how injury occurred 1 ☐ Yes 2 No ၉ 2 ER/Outpatient 3 DOA this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After Certification: 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours efter deat Funeral Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical To the Hosp within 24 ho To the Fund completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of confifier 29c. License number 06 w

DHMH 17 Rev 1/2001

State

Registrar

Baltimore. Maryland 21215-0036

Box 68760

P.0.

Records.

Division of Vital

Carolyn Caine, M.D. 11701 Livingston Road, Fort Washington, MD 20744

30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

APR 2 4 2006

31. Date filed (Month, Day, Year)

			1 - State Registrar	State of Maryla		artment of He rtificate of D		ental Hygie		12682
			Decedent's Name (First, Middle, Las	it)				2. Date of Death		3. Time of Death
	Physici /Medio		Thomas Osborne	Anderson				April 21	Day 2006	2:34pm M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or I	Location of Death		4c. County of Dea	th
			Greater Baltimo	ore Medical C	Center	Towson			Baltimor	e
	Funeral Director		210 20 .000	7. Age (In y	rs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Yes	9. Bin Co	thplace (State or Foreign puntry)
	pud *		Usual Residence of Decedent 10a. State 10b. County	100	City, Town or Lo	ecation				10d. Inside City Limits
	Marylt f sho	or	MD. Baltimo		imonium					1 ☐ Yes 2 ☑ No
)	28a-	rect	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	ountry?
	h with	i Di	2525 Potspring Ro	oad L503		21093			USA	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic svent, the Medical Examinal must be mullind at once.	l by Funerai Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If YAs, Give Year or Dates:		Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2☐ Wo	spanic Origin? (Spe i, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: W	
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2	shoulk nd Me mark matic	P	19a. Informant's Name/Relationship (7		19b. Mailir	ng Address (Street ar				Zin Code)
Z	lith ar 27 is r trau		Mr. Todd Anderso			Cinder Roa				1093
ē,	s 1 ar		20a. Method of Disposition	208	b. Place of Dispo				. Location - City or	Town, State
Baltimore,	Page nent o int: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Departion 5 🕱 Other (Specify	Removal from State) Entombment [_ *	Valley Mer			Timonium.	Maryland
alti	permit. Departmine imports any injuited.		21. Signature of Funeral Service Licen		_	2. Name and Address			son Funer	al Home, Inc
Ω_	20 = 50		Moste		1	050 York I	Road, Tow	son, Mary	/land 212	04
			23a. Part1. Enter the disease, or companies shock, or heart failure. List only	plications that caused the done cause on each line.	leath. Do not ent	er the mode of dying.	, such as cardiac o	r respiratory arrest,		Approximate Interval Between
7	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Suba	YUCKI sequence of):	noid t	temon	hage	-	Onset and Death
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<u>=</u>	ysicia is cert directi	o Be	examiner?	Hospital: 1 (Anpatient 2	□ EP/Outpation		26. Place of Death	Check only one)	2 DON (2	
o	g Phy ler this neral d	5 To	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury a	at 2	8d. Describe how in		cify)
<u>ö</u>	ath. r: Afte	ation	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year	r) Injury		es 2 🗆 No			
Division	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	at home, farm, str	eet, factory, office	2	8f. Location (Street City or Town, St		ıral Route Number,
	Hospit 24 hours Funera	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my liner: On the basis of exam and manner stated.	knowledge, death ination and/or inv	n occurred at the time vestigation, in my opi	e, date and place, a nion, death occurre	nd due to the cause od at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	2 2 2 2					29c. License	number	29d.	Date signed (Monti	
	To the within To the comple	×	29b. Signature and title of certifier CYN HWA SN	iam no			05134	7		
1	To the comple	M		pompleted cause of death //	Item 23a) (Type,	DO			4/22/	06
/	Sta Registr	te	30. Name and address of person who cyntuig Soria 31. Date filed (Month, Day, Year)	pompleted cause of death //	701 N	Do Print) Chanes			4/22/	06

DHMH 17 Rev 1/2001

		1 - For State Registrar	State	of Marylai		artmen <i>rtificat</i>			and M	ental Hy	giene Reg. No.	006	12683
× =		1. Decedent's Name (First, Middle, L	ast)							2. Date of De	eath Day	Year	3. Time of Death
Physici /Medic		Edna Frances	Botto	orf						April			5:15 pm
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		Manor Care Health	n Servi	ces		Ross	vill	.e			В	altimor	e
Funeral		5. Social Security Number 6.	Sex	7. Age (In yrs	. last birthday)	If Under	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Bid (Month, Da	rth av Year)	9. Birt	hplace (State or Foreign
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P		Usual Residence of Decedent		10.0	ity, Town or L								
show	<u>_</u>	10a. State 10b. County		100.0	ity, Town or Li	ocation							10d. Inside City Limits
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dosp hon une siy fil	edical	29a. Certifier 1 ☐ Certifying F	Physicien: To the	ne best of my kn basis of examin	owledge, deal	th occurred	at the tim	e, date and	d place, a	and due to the	cause(s)	and manner as	stated.
To the Hospital or Attanding Physician: The law requires that the death certific within 24 hours atterdeath. To the Funeral Director: After this certificate has been signed by the attending population of the Funeral Director attending to the Funeral Director. After this certificate has been signed by the attending to the funeral director, page 2 should be detached for use as	led	one)	and ma	nner stated.		· ·							
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U		30. Name and address of person who	completed cau	use of death (Ite	m 23a) (Type,	Print)	Α.	G- 1	· p-	200	RAI	7104 00	E M. 2
		VITOAIIS A. HA	THMI	MD, &	2(N)	FUT	AN	7 7	nu	209.		- ITYVVIL	U 1/(1) 2/26/
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DHMH 17 Rev 1/2001

			1 - For State Registrar	State			d / Depa		t of H	ealth a	and M	ental Hy		111115	12684
- Art	Physici /Medic		1. Decedent's Name (First, Middle Helen A.	Bass								2. Date of De Month Apri.1	20	2006 Year	3. Time of Death 12:33p M
	Examir	er	4a. Facility Name (If not institution 3503 Westview	Road		4		W∈	estmi	Location of	r			Carrol	1
***************************************	Funeral Director		5. Social Security Number 213-34-9184 Usual Residence of Decedent	6. Sex 1 ☐ M 2 ☐ X F	69	(In yrs. I	ast birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bi (Month, Da Nov 14	ay, Year 19:	36 MD	thplace (State or Foreign ountry)
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	th with the 23a or 28	al Dire	10e. Street and Number 3503 Westview	Road				10f. Zip	Code 2115	57			10g. C USA	itizen of What Co	ountry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: if Item 27 is marked other than "natural", or Iteme 23e or 28e-f ahow any injury or other traumatic event, the Medical Exaction must be routiled at ance.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was De Armed F ned 1Yes If Yes, G Year or	orces? 2 🔯 No ive			Was Deced f Yes, spec 1 ☐ Yes		spanic Ori n, Mexican Specify:		cify Yes or No Rican, etc.)	0-	14. Race - Ame Black, Whit Specify: Wh	te, etc.
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, Mar	and 2 sho saith and I n 27 is ma		19a. Informant's Name/Relations David P. Bass		se)		3503	Westv	iew	Rd.,				or Town, State, 2 Id 21157	
Baltimore,	Pages 1 nent of He ant: If Iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		1 State		ace of Dispo emetery, crem e View	Memo	rial	. 4	4-24-		Syke	ocation - City or esville,	Md
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	Physician /Medical Examiner	ıer	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ab.	each line.	ZH consequ	E/ME ence of):		_				urrest,		Approximate Interval Between Onset and Death
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Division	To the Hospitel or Attent within 24 hours efter death To the Funerel Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 286. Plac	e of Injury ding, etc.	/ - At hor (Specify	me, farm, str	eet, factory	, office		2	8f. Location (City or To	Street a wn, Stat	nd Number or Ri e)	ural Route Number.
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)	To t Within	Σ	29b. Signature and title of certifie	Sall	tu			290	License	number 263	28		29d. Da	ate signed (Mont	h, Day, Year)
	5		30. Name and address Person	who completed car	118	wa	show	Print)	Hei	ght	Kell	red (rer	21-0 west	21157
	Sta Registi		31. Date filed (Mon A. D. Q. Yar)	4 2006 32	egistrar	s Signat	16 16	sail !							

			For State Registrar	State of Ma	ryland / Depa. <i>Cei</i>	artment of H		-	iene 006	12685
			Decedent's Name (First, Middle, Last)					2. Date of Deal	th	3. Time of Death
	Physicia /Medic	-	NORMA Alberta	E	BITTNER			April	Day Yeer 20,2006	2:20 a. M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Deat	h	4c. County of Dea	th
			Manor Care Rossvi			Baltir			Baltin	
	Funeral Director		5. Social Security Number 6. Security Number 15-05-3510		(In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day March I		hplace (State or Foreign ountry) INSylvania
die die	*		Usual Residence of Decedent						.,, ., ., ., .,	
	death with the Maryland ms 23s or 28e-f show		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	e Ma	Director	Maryland Baltimore	2	Middle	River				1 ☐ Yes 2 No
	ith th	Dire.	10e. Street and Number			10f. Zip Code	•	1	0g. Citizen of What Co	ountry?
	s 23s	ra	6707 University D			212		Jane H. Wan as No.	U.S.A.	ricen Indian
	ltem Item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 X X	ver in U.S. 13. 1	Was Decedent of H f Yes, specify Cuba	in, Mexican, Puer	to Rican, etc.)	Black, Whit	
ဌ	urs aff	by F	3: Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1□Yes XXNo	Specify:		Specify:	White
0500-CI	72 hor	Completed	15. Decedent's Edu (Specify only highest grad	cation	16a. Deced	dent's Usual Occup	ation	rkina	16b. Kind of Business	
Ž	thin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5-	+) life. I	DO NOT use retired	t)	Mily		
V	ygien ygien yer th			2 yrs.	Hon	nemaker	40 Mark at Mr.	- Cina Middle	Own Home	
and	iid be filed within 72 hours after death with the Marylan lental Hyglene ked other than "natural", or Items 23a or 28e-f show ite event, its Medical Examinal must be molified at	Be	17. Father's Name (First, Middle, Last)		Noe			me (First, Middle, I	walden Sumame) Leb	22
>	2 should be and Mental is marked (2	Albert 19a. Informant's Name/Relationship (Ty	rna Print)		on Address (Street	Maria	ural Route Number	City or Town, State,	
Z Z	ges 1 and 2 should t of Health and Mer If item 27 is marke or other treumatic		John R. Bittner Jr.						bottstown,	
ē,	is 1 and of Health item 27 other tr		20a. Method of Disposition	• (5011)	20b. Place of Dispo			Date	20c. Location - City or	Town, State
Ē	Pages nent of int: If it iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)		Green Mount		" 4 -	21-06	Baltimore, Ma	rvlard
Baltimor	permit. Pages Department of I Important: If it any injury or o		21. Signature of Funeral Service Licent				ss of Facility	old F U	Tro	- Janes
ă	8 9 E 8		Chert Brat	3		6500' Yo	rk Road	Baltimore	Inc. e,Maryland	21212
			23a. Part1. Enter the disease, or compi shock, or heart failure. List only or	ications that caused ne cause on each line	the death. Do not ent	er the mode of dyin	g, such as cardia	c or respiratory arr	est.	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	CANC	er es	OPHAG	LOUS			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):	A. C. (1.10) 18				
	Examine,	_	Sequentially list conditions,	Due to for an a	Leonsaguenes of):					
	ted nsit	nlne	Sequentially list conditions, if any, Isaamy to immediate cause. Enter Underlying Cause (Disease or injury	000 10 (01 00 0	i concoquenco oi).					
,	execunand nandial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequence of):					
8/9N	death certificate be executed e attending physician and nd for use as the burial-transit	dical		d						
Õ	rtifica ng ph as th	Medi	IF CENALS.							
X Q	leath certific attending p	an/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome o		Ectopic pregnancy	,		23d. Date of de Month	livery Day Year
o.	at the dea by the al	Physician/Me	1 Yes 2 No	4□Pregnant at t 9□Unknown	time of death 5	Other (specify)				22,
J.	requires that the leen signed by th hould be detache		Part II. Other significant conditions con	ntributing to death bu	it not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute to	the cause of death?
ďS,	uires sign	d by						1 🗆 Y	es 2 No 3 P	robably 4 Unknown
S	> 10	lete						24a. Was a	n 24b. Were a	utopsy findings available
Vital Record	The law sate has b page 2 st	Completed						autops	med? prior to death?	completion of cause of 2 □ No
ā	iician: Th certificate rector, pag	a	25. Was case referred to medical				26. Place of De	1 ☐ Yes : ath (Check only on		2 140
	d is	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatier	nt 2 ER/Outpatier	nt 3 DOA Oth	er: Nursing h	Home 5 Reside	ence 6 Other (Spe	cify)
n of	ding Ph h. After th funeral		27. Manner of Death 1 ★ Atural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Time o (Year) Injury	Wor	k?	28d. Describe ho	ow injury occurred	
SIO	death. ctor: A the fu	catle	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □No			
Division	ire ire	Certification:	4 Homicide determined	28e. Place of Inju building, etc	iry - At home, larm, str (Specify)	reet, factory, office		City or Town	treet and Number or R n, State)	ural Houte Number,
_	To the Hospitel of within 24 hours af To the Funerel D completely filled in		29a, Certifier 1 Certifying Phy	sician: To the hest of	of my knowledge deat	h occurred at the tir	ne, date and place	e, and due to the o	ause(s) and manner a	s stated
	24 hc 24 hc Fun etely	Medical	(Check only 2 Medical Exami	ner: On the basis of and manner sta	examination and/or in	vestigation, in my o	pinion, death occi	urred at the time, d	late and place, and du	o to the cause(s)
	To the Hospitel within 24 hours a To the Funerel I completely filled	Me	29b. Signature and title of defilier	(1)		29c. Licens	e number	2	9d. Date signed (Mon	th, Day, Year)
1	. , , , ,		Ja Winiper	en X		DO	06056	5 1	SPRIL 20	,2006
	()		30. Name and address of person who co	cause of de	eath (Item 23a) (Type,	Print)				
_	10		201 Back Riv	er I Nec	k Rd S	inite	109 8	55ex 1	ND 2122	- (
	Sta Regist		31. Date filed (Month, Day, Year) APR 2 4 20	32. degistra	ur's Signature	ale				
	1109101		1,41 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/	7 C C C C C C C C C C C C C C C C C C C						

DHMH 17 Rev 1/2001

		•	For State of M	aryland / Depa	artment of H			ene 0 0 6	12687
i	Physici	an	1. Decedent's Name (First, Middle, Last)		***************************************		2. Date of Death Month	Day Year	3. Time of Death
	/Medic	cal	Alfred Thomas Bailey, Jr. 4a. Facility Name (If not institution, give street and number)		4b. City. Town, or	Location of Death	April	18 2006 4c. County of Death	05:50 PM
ř.	Examin	ıer	Laurel Regional Hospit	al	Laurel			Prince G	
	Funeral		5. Social Security Number 6. Sex 7. Aq 215 58 9362 1₩ M 2□F	e (In yrs. last birthday) 53 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth A(Month: Day,)	(Pag) 52 9. Birth	place (State or Foreign intry)
	Director		Usual Residence of Decedent				11P1 11	Wasl	7
	ehow	5	MD Prince George	Laure1	ocation				10d. Inside City Limits 1 Yes 2 No
	the N	Director	10e. Street and Number	Dadrer	10f. Zip Code		100	g. Citizen of What Cou	
	th with	ai D	14800 4th Street		20707			U.S.A.	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show appringing or other treumatic event. If a Medical Exatr partment is notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Agned Forces: 1 X Yes 2 If Yes, Give Year or Dates:	No	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 No	spanic Origin? (Spanic Origin?) n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: W	
5-0036	72 hor	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of works	ing 16	6b. Kind of Business/I	ndustry
121	within 72 ene. than "nal	Completed	Elementary/Secondary (0-12) College (1-4or	Mech)		.s. gove	rnment
2 2	be filed htal Hygie ed other event. I	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, Ma	aiden Sumame)	
Maryland	2 should be and Mental is marked of eumatic ev	To E	Aftred Thomas Bailey,				ine Sim		- 0- 4-1
	ad 2 sh alth and 27 is n r treun		19a. Informant's Name/Relationship (Type, Print) \$andy Bailey, DAughte		-			City or Town, State, Zi MD 2070	
Baltimore,	es 1 ar of Hea of Hea of Hea of Item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo cemetery, crei	osition (Name of matory or other place	Θ)	Date 20	c. Location - City or T	own, State
ᆵ	t. Pages tment of I rtant: If it		4 ☐ Donation 5 ☐ Other (Specify)	The second secon	ille,Cen			Crownsvi	
Ba	Departr Departr Importa any inju		21. Signature of Funeral Service Licensee	7		dy Sprin	g Ra. L	neral Ho aurel, M	D 20707
	Physician		23a. Part1. En/fer the disease, or combinations that cause shock, or heart failure. List only one cause on each I Immediate Cause (Final disease or condition	on the death. Do not ent on thial	ter the mode of dying	g, such as cardiac o	or respiratory arres	t,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as	a consequence of):	uctive	Rulina	1	2000 40	nide Tuess
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a consequence of):	active	3 CONTON !	wy 5	seare	Jacob
	ecuted and I-transi	Examiner	Cause (Disease or injury that initiated events c.	a consequence of):	6 H	sosure			
760,	ate be executed hysicien and the burial-transit	cal E	d					77 1-100.00	
89	ertificating physe as the		IF FEMALE:						
O. Box	Physicien: The law requires that the death certifica this certificate has been signed by the attending ph rail director, page 2 should be detached for use as the	by Physician/Med	23c. If yes, outcome	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delik Month	rery Day Year
Q	w requires that been signed b should be deta		Part II. Other significant conditions contributing to death	out not resulting in the u	nderlying cause give	en in Part I.		cco use contribute lo 2 □ No 3 Pro	the cause of death? bably 4 □Unknown
l Records,	ding Physicien: The law re h. After this certificate has ber funeral director, page 2 sho	Completed					24a. Was an autopsy performe	prior to c death?	opsy findings available ompletion of cause of
Vita Vita	sicien: certific rector,	Be	25. Was case referred to medical examiner? Hospital:	**	othe Othe	200	(Check only one)		
ŏ	g Phys er this eral di	n: To	27. Manner of Death 28a. Date of Injury		" 3DDOA	4 🗆 Nursing no	me 5 ☐ Residen 28d. Describe how	ce 6 Other (Spec	1(y)
sion	Attending r death. sctor: After by the funer	atio	2 ☐ Accident investigation	injury		Yes 2 □ No			
Division of Vital	Hospital or Attent 44 hours after deatl Funerel Director: tely filled in by the	Certification:	determined 288. Place of in	jury - At home, farm, sti ic. <i>(Specify)</i>	reet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	al Route Number,
	To the Hospital or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Physician: To the best (check only one) 2 Medical Examiner: On the basis and manner s	it examination and/or in	h occurred at the time vestigation, in my op-	ne, date and place, pinion, death occurr	and due to the cau ed at the time, dat	se(s) and manner as e and place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier		29c. License		290	Date signed (Month	
	10		440	- CA PILL		1271	F	Ipril 21	- 2066
V			30. Name and address of person who completed cause of SYEA SALW, 14333	LAULELBO	WIE ROX	3. Ste.	208 LH	turel M	1 20708
	Sta Regist		31. Date filed (Month, Day, Year) 32. P. jist APR 2 4 2006	rar's Signature	mark)				

06-02665 Ronald Chartrand Please Type or Print in Black Indelible Ink Amend item 200 per me 8857 44-14-06 Wt State of Maryland / Bepartment of Health and Mental Hygiene

	1- For State Certifica	te of Death Re	g. No. 2006 12688
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) Ronald Albert Chartrand Jr	2. Date of Death Month April 19, 20	
	Facility Name (if not institution, give street and number) Upper Chesapeake Medical Center	4b. City, Town, or Location of Death Bel Air	4c. County of Death Harford
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthe	day)	n(MM/DD/YYYY) 9 Birthplace (State or Foreign Country:Maryland
faryland 28a-f show any at once. ector	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or BelAir		10d Inside City Limits 1 Yes 2 XXNo
th the Maryland 23a or 28a-f sho notified at once.	10e. Street and Number 112 Seevue Court	10f. Zip Code 10 21014	g Citizen of What Country? USA
s after death wi ral", or items iner must be by Funera	3 VVIdowed 4 Divorced in res, Give rear or Dates:	13 Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes XX No specify: ecedent's Usual Occupation (Give kind of work done)	14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry
5-0036 ed within 72 hours of yegiene. other than "natu the Medical Exan	Elementary/Secondary (0-12) College (1-4 or 5+)	uring most of working life. DO NOT use retired) Writer	Journalism
y, MD 21215-0036 and 2 should be filed within 72 teath and Mental Hygiene. tem 27 is marked other than traumatic event, the Medical To Be Comple	Ronald Albert Chartrand Sr	18.Mother's Name (First, Middle, M Martha Blair	Norris
MD 2121. nd 2 should be ff ulth and Mental 1 m 27 is marked aumatic event,	Joann Beth Chartrand Wife 11	Mailing Address (Street and Number or Rural Route Num 12 Seevue Court BelAir Mary	land 21014
Baltimore, ME pernit. Pages I and 2 si Department of Health an Important: If item 27 injury or other trauma	1 Burial 2 XX Cremation 3 Removal from State cremator	Disposition (Name of cemetery, yor other place) Nount Cemetery 22. Name and Address of Facility M11C1e - 12	
Physician	23a Part I. Enter the disease, or complicity as that caused the death. Do not failure. List only one cause on each line. Narcotic (Hydroco	enter the mode of dying, such as cardiac or respiratory arre	imore, Maryland 21212 st, shock, or heart mplicating Between Onset and
/Medical xaminer	Immediate Cause (Final disease or condition resulting in death) a. hypertensive cardiova Due to (or as a consequence of):	xione and franktion) intoxicación c ascular disease	Death Death
niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		
cuted fransit			
760, Create be executed freate be executed the burial - transit the burial - transit in Medical Ex.	IF FEMALE: 23c. If yes, outcome of pregnancy	7,28a-f,perME,g856,6/7/06 TT	23d. Date of delivery
b. Box 687 the death certific by the attending p ched for use as the	IZSD. VVas decedent prednant in the	Fetal death 3 Ectopic pregnancy Other (Specify)	Month Day Year
s, P.O. irres that the signed by to deeche			pacco use contribute to the cause of death? 2 No 3 Probably 4 V Unknown
Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certiff within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as redical Certification: To Be Completed by Physician		24a. Was a autop: perfor 1 🗸 Yes 2	prior to completion of cause of death?
Vital ysician: this certif director,	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Out	26.Place of Death (Check only one) patient 3 DOA Other Mursing Home 5	Residence 6 Other
on of on of ath or. After the funeral tion: T	27 Manner of Death 28a Date of Injury 28b T	me of Injury 28c. Injury at Work? 28d Describe P	ow injury occurred
Division o spital or Attending tours after death neral Director: Aft filled in by the func Certification:	2 Accident Investigation 3 Suicide 6 X Could not be determined (Specify) House	2.00 Pm	treet and Number or Rural Route Number, City ate) II2 Seevue Court Apt F
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the ledical Certificatif	29a Certifier Check only 1 Certifying Physician: To the best of my knowledge, deal one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, and due to the caus- vestigation, in my opinion, death occurred at the time, date	e(s) and manner as started.
T % T % Me	29b Signature and title of certifier 7 7	29c. License number O.C.M.E.	29d Date signed (Month, Day, Year) 4-20-06
6		enn Street, Baltimore, MD 21201	
State Registra		forti	
DHMH 17 Rev 1/2001		GINAL	

			For State Registrar	State of Maryland / Depa	artment of Healt rtificate of Dea		ntal Hygier		12689
100	Physici	an	1. Decedent's Name (First, Middle, Last)			2.	Date of Death Month	Day Year	3. Time of Death
1	/Medic		Gordon	J. Cook			04 2	1 2006	4.53 AM
	Examin	er	4a. Facility Name (If not institution, give s	TAN HOSPITAL	4b. City, Town, or Local BALTIMOI			4c. County of Death	Α.
52	Funeral		5. Social Security Number 6. Sex		If Under 1 Year If Ur	nder 24 Hrs. 8.	Date of Birth	9. Birth	place (State or Foreign
	Director		212-16-6564	2□F 85 Yrs.	Months Days Hou	urs Min.	Date of Birth (Month, Day, Ye.	1921	MS.
	pu &		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or Lo	cation		1		10d. Inside City Limits
	Aaryla Fehor ed at	ō			idole Rive	0			1 Yes 2 No
	28a-	Director	10e. Street and Number		10f. Zip Code	~	10g.	Citizen of What Cou	ntry?
	h with		1900 Grove 1	MANOR RD	212	9-0		U.S.F	A .
	death	Funeral			Was Decedent of Hispani If Yes, specify Cuban, Me		y Yes or No-	14. Race - Ameri Black, White,	can Indian,
36	hours after death with the Maryland lurel; or Iteme 23a or 28e-f ehow al Examinar rouat be notified at	by Fu	1 Never Married 2 Married	1 Yes 2 No U.S. If Yes, Give		ecify:	. ,		vite
21215-0036	naturel;		3 Widowed 4 Divorced	Year or Dates: ARMY	dent's Usual Occupation		16b	. Kind of Business/Ir	
715	d within 72 ho jiene. r then "netur Ine Medical	Completed	(Specify only highest grade Elementary/Secondary (0-12)	(Give	kind of work done during DO NOT use retired)	most of working			,
212	d within glene. er then	Com	1045	NA	TRUCK DR	iveR	T	RUCKING	•
	be filed stal Hygi of other event, I	Be	17. Father's Name (First, Middle, Last)	i.		4	First, Middle, Maid		
yla		^L	Cliffon Con			arg aret	BAKE		- C- d-1
Maryland	カイトサ		19a. Informant's Name/Relationship (Ty		GOUE MAN			***	21220
ē,	s 1 and if Health Item 27 other tr		20a. Method of Disposition	20b. Place of Dispo		Date		. Location - City or T	
Baltimore			-1-☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	PARK U201	ob Cem.	4/25/	o 6	Balto MD.	•
alti	permit. Page Department of Important: If eny Injury or once.		21. Signature of Funeral Service License	90	2. Name and Address of F	Facility NERA	1 Home,	PA.	
	80E 5 8		faul In.	JULA 1-	1527 harror	CX ICD. P	A ITO, JUV)	21734	7
10 to 10 to	Physician /Medical		Shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):					Approximate Interval Between Onset and Death
2.	Examiner	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):	HRONIC P	RENAL	FAILU	RE	
8760,	cate be executed physicien and the burial-transit	dical Examine	that initiated events resulting in death) Last	Due to (or as a consequence of):					
9	entificating phone as the	Medi	IF FEMALE:						
.O. Box	The law requires that the death certific the seen signed by the attending plage 2 should be detached for use as in	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
0	es that igned b	by Pi	Part II. Other significant conditions con	ntributing to death but not resulting in the u	nderlying cause given in F	Part I.	23e. Did tobacc	co use contribute to	the cause of death?
rds	w require been sig should b	ed t	Atnal FIBRICLAT	TON, CHRONIC OS	STRUCT/YE		1 🗆 Yes	2 No 3 Pro	bably 4 Unknown
of Vital Records,	law re les be	Completed	PULMONARY DISC	EASE CHRONIC K	CENAL FAIC	CURE	24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
E E		Con	CONGESTIVE HEA	ART FALLURE, DIA	BETES ME	CLITUS	performed	No 1 ☐ Yes	2□ No
Vita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?		26. 1	Place of Death (
	Physical dii	2	1 ☐ Yes 2, Ø No 27. Manner of Death	10spital: Inpatient 2 ER/Outpatier 28a. Date of Injury (Month, Day Year) 28b. Time o	1 3 DOA 41		5 Residence d. Describe how in	6 Other (Speci	fy)
lon	Attending I r death. ector: After by the funer	atlor	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury	Work? M 1 ☐ Yes	2 🗆 No			
Division	ppitel or Attendi ours after death. ierel Director: A filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28	Location (Street City or Town, St	t and Number or Rur tate)	al Route Number,
	To the Hospitel or A within 24 hours after To the Funerel Direction plately filled in by	edical	(Check only 2 Medicel Exami one)	sician: To the best of my knowledge, deat ner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion	n, death occurred	at the time, date	and place, and due t	to the cause(s)
	To t Som	Σ	29b. Signature and title of centrier	nan	29c. License num			Date signed (Month,	*
,	0		▶ n xam		RES C	000		24-21-1	06
1	7		30. Name and address of person who co	ompleted cause of death (Item 23a) (Type, DEY 5601 LOCH R	Print) AVEN RIVE	d. Rns	TIMMEE	MAKUIN	ND-21930
	Sta	ite	31. Date filed (Month, Day, Year)	3 A istrar's Signature	774677 5176	11 346	· Irrion Cy	171717 4	דכרות-עוו
	Regist		APR 2. 4. 200	6 Keep M Rose	all B				

YORDON

		1 - For State Registrar	State of Maryland		rtment of H tificate of I			eg. No.	12690
21		Decedent's Name (First, Middle, Last)	<u> </u>				2. Date of Deat Month		3. Time of Death
Physic /Medi		JANICE	COOK				APRIL	21,200	6 5:45 PM
Examir	ner	4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Death		4c. County of De	5
Funeral		5. Social Security Number 6. Sex	HOSPICE 7. Age (In yrs. las	st birthday)_	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		T(NOR) irthplace (State or Foreign Country)
Director		215-44-0154 1	M 32 66	Yrs.	Months Days	Hours Min.	(Month, Day,	(1945	MD.
pus *		Usual Residence of Decedent 10a. State 10b. County	10c. City.	Town or Loc	ation				10d. Inside City Limits
Marylan f •how	ō		TMORE		Perry	HAIL			1 Yes 2 No
r 28a	rec	10e. Street and Number			10f. Zip Code	2 (11)	1	0g. Citizen of What (Country?
th with	a D	40 SURREY	LANC		2	1236		U .:	S,A.
er dea	Funeral Director		12. Was Decedent Ever in U.S. Amed Forces?	13. W	as Decedent of H Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	nerican Indian, nite, etc.
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28s-f ehow sumatic event, the Medical Examinar must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1	Yes 20 No	Specify:		Specify:	white
72 hou	ted	15. Decedent's Edu (Specify only highest grade	cation	16a. Decede	ent's Usual Occupa	ation during most of work	ina	16b. Kind of Busines	ss/industry
ithin 7	Completed	Flementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retired	2	ing .	Hone	
Hygier ther t		17. Father's Name (First, Middle, Last)	NIA		Housew	18. Mother's Name	e (First Middle I		
id be ental	To Be	7. 0	MISANO					1000	
nd 2 should be filed within all and Mental Hygiene. 27 is marked other than it traumatic event, Italian	-	a. Informant's Name/Relationship (Ty		19b. Mailing	Address (Street	and Number or Rur.		, City or Town, State	, Zip Code)
in c, intally lailed within 72 hours after death with the Maryla if health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28s-f ehow other traumatic event, the Medical Examinar must be notified at		ROBERT -T. C.	ooK		SURREL		13AHa. 1	MD 212	36
Pages 1 nent of H. ant: If ite		20a. Method of Disposition 1 Burial 2 Cremation 3 R		ce of Dispos netery, crem	ition (Name of atory or other place		/	20c. Location - City of	111111111111111111111111111111111111111
it. Pa intmen intent: njury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		Don t	ARK CEI			BALTO. MS) .
permit. Pages 1 end 2 Depertment of Health a importent: if item 27 is any injury or other tra		Haul M. S	tells	Pa	JULSTE	ILA Fune	LACHOI	me, PA. Ms 212	34
		23a. Part1. Enter the disease, or compli	cations that caused the death. e cause on each line.						Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)	Cancer	Timer					Onset and Death
/Medical Examiner		Tosaking in county	Due to (or as a conseque	nce of):					
	Jer	Sequentially list conditions, it any, leading to immediate	Due to (or se a conseque	riou of):					
icuted nd Iransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
be exected a		resulting in death) Last	Due to (or as a conseque	nce of):					
icate physics the l	edical								
onding use a		IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pregnand					23d. Date of d	lelivery
b death	Physician/M	in the past 12 months? 1 ☐ Yes 2 D No	1☐Live birth 2☐Fetal d 4☐Pregnant at time of dea 9☐Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
hat the		9 ☐ Unknown N		ing in the unc	deriving cause give	on in Part I	23e Did tot	nacco use contribute	to the cause of death?
uires l signe	d by				g				Probably 4 Unknown
s beer s shou	Completed						24a. Was a		autopsy findings available
The la	E O						autops perform	ned? death?	o completion of cause of es 2 No
cian: entific actor.	Be (25. Was case referred to medical examiner?			i ou	26. Place of Deat	(Check only on	6)	
Physi rthis c ral dir	. To	1 Yes 2 No		R/Outpatient 8b. Time of		T I I I I I I I I I I I I I I I I I I I		ence 6 Quther (Sp.	pecity) hospice
th. Afte	ation	1 Naturat 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	28c. Injun Work M 1 □	(? Yes 2 □ No		many coodings	
r Atts	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (St City or Town	reet and Number or i	Rural Route Number,
urs aft prel Di									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	(Check only 2 Medical Examinations)	rician: To the best of my knowlers: On the basis of examination and manner stated.	adge dealf n and/or inve	occurred at the tin estigation, in my or	ie, date and place pinion, death occurr	and due to the co ed at the time, d	ate and place, and di	ue to the cause(s)
To the within To the comple	Me	29b. Signature and little of certifier	n		29c. License	number	2	9d. Date signed (Mo	nth, Day, Year)
		> Dua	lus		DS	8303		April 2	(200g
5		30. Name and address of person who co	mpleted cause of death (Item 2	3a) (Type, P	Print) CU	arks Sr	BATU	ne un	21204
Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatur		and a				-
Regist	rar	APR 2 4 20	05	2 /	nols D				

DHMH 17 Rev 1/2001

4.21.06 5:45PM

COOK, JANICE

		1 - For State Registrar	State of M	aryland / D	epartment of Certificate of	f Health a of Death	and Mental Hy	giene 0 6	1 100 0 10
3/81	sician edical	1	etrich				2. Date of De. Month April	20 200	-
	miner	Waldorf Health	ncare Cer		Wald			4c. County of 1	les
Fune Direc			1☐M 2□F		rs. Months Da		Min. (Month, Da		. Birthplace (State or Foreign Country) [aryland
Maryland -f ehow	to.	10a. State 10b. County	County	10c. City, Town	or Location antown				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
with the	Director	10e. Street and Number			10f. Zip Cod	20617		10g. Citizen of Wha	-
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. ie marked other than "naturel", or items 23e or 28e-1 ehow all main event the Mental Franchise and the standard of the second that the Mental Research of the second that the Mental Research of the second that the Mental Research of the second that the Mental Research of the second that the Mental Research of the second that the Mental Research of the Me	by Filneral	3 XWidowed 4 □ Divoroed	12. Was Decedent Armed Forces 1 MYes 2 If Yes, Give Year or Dates:		13. Was Decedent If Yes, specify C	of Hispanic Orig Juban, Mexican	gin? (Specify Yes or No , Puerto Rican, etc.)	USA 14. Race - Black, V	American Indian, White, etc. White
Maryland 21215-0036 nd 2 should be filed within 72 hours at lith and Mental Hygiene. "27 le marked other than "naturel", or transmic aven than "naturel", or	Completed	15. Decedent's 8 (Specify only highest g	rade completed) College (1-4or		Decedent's Usual Oc Give kind of work do life. DO NOT use re Supervis	ne during most tired) SOC		Uti	ess/Industry Electric lities
/iand utd be file Mental Hy irked oth	To Re	17. Father's Name (First, Middle, Las		, Sr.			r's Name <i>(First, Middle,</i> Cilda	Wolfe	
i, Maryla and 2 should saith and Men n 27 te marke		19a. Informant's Name/Relationship Ann H. Lancaste:			-		r o <i>r Rural Route Numbe</i> Lve Bryant		
of He		20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other (Spec	☐Removal from State	20b. Place of cemetery	Disposition (Name of crematory or other	olace)	Date	20c. Location - Cit	
Baltim permit. Pag Department important:	Suce.	21. Signal of Funeral Serve (c) Martin D. La	Lawson		Mitchell	dress of FacilityWiedel	eld Funera	1 Home, I	nc.
Physici /Medic		23a. Part1. Enter the disease, or cor shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	ALTEL (ne.	one a		ASCULAN		Approximate Approximate Interval Between Onset and Death
8760, sate be executed with the burial-transit the burial-transit transit.	E a	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulling in death) Last	b. — Due Io (or as	a consequence o	·):				
68760 cate be e	dicai		d	•					
that the death certific ted by the attending prepared for use as:	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	3 ☐ Ectopic pregna 5 ☐ Other (specify			23d. Date o Month	,
Records, P.O. The law requires that the tte has been signed by the tage 2 should be detached.	2	Part II. Other significant conditions	contributing to death t	out not resulting in	the underlying cause	given in Part I.	23e. Did to		ite to the cause of death? Probably 4 Unknown
Vital Records, sician: The law requires to certificate has been signs	1 2						24a. Was autop perfo 1 Yes	rmed? dea	re autopsy findings available r to completion of cause of th? Yes 2 \[\] No
of Vita Physician: rthis certific	Re C	25. Was case referred to medical examiner?	Hospital:	ent 2 ER/Out	patient 3 DOA	Othor	of Death (Check only o		(Specify)
Division of Vital Re To the Hospital or Attending Physician: The within 24 hours after death. To the Funderal Director: After this certificate his compliable filled in by the funderal director page	ation. T		28a. Date of Inju (Month, Da		me of 28c. I	njury al Work? Yes 2	28d. Describe l	now injury occurred	Specify
DIVIS	Certification.	3 Suicide 6 Could not 4 Homicide determine	289. Place of in	iury - At home, fan ic. <i>(Specify)</i>	n, street, factory, offi	ce	28f. Location (S City or Tov		or Rural Route Number,
To the Hospital or within 24 hours after To the Funeral Director of the foundation o	polical	29a. Certifier 1 Certifying F (Check only 2 Medical Execution)	hysician: To the best nminer: On the basis of and manner st	f examination and	death occurred at th for investigation, in m	e time, date and ny opinion, deat	d place, and due to the h occurred at the time,	cause(s) and manne date and place, and	er as stated. due to the cause(s)
To the I within 2 To the I	3	29b. Signature and title of certifier			29c. Lic	ense number	45	AMIL 2	10nth, Day, Year) 21, 2006
10		30 Name and address of person who	completed cause of	death (Item 23a) (1	ype, Print)	UE Œ	exter u	AWORF,	21, 2006 Md. 20602
Reg	State Jistrar		32 Regist	rar's Signature	(all				

			_ FUI	eartment of Health and Mental ertificate of Death	Hygiene Reg. No. 006 12692
U	Physici		Decedent's Name (First, Middle, Last) GEORGE H. F. ENSOR	Mon	of Death 3. Time of Death 2:00 A. M
	/Medio Examin	er	4a. Facility Name (If not institution, give street and number) 1323 BURLEIGH ROAD	4b. City, Town, or Location of Death LUTHERVILLE	4c. County of Death BALTIMORE
	Funeral Director		5. Social Security Number 212-10-2387 6. Sex 7. Age (In yrs. last birthday 97 Yrs.	// Months Days Hours Min. 8. Date (Mor 11 -	e of Birth nth, Day, Year) 26-1908 9. Birthplace (State or Foreign Country) MARY LAND
	ith the Maryland or 28a-f ehow se notified at		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	LUTHERVILLE	10d. Inside City Limits 1 ☐ Yes 2 XX lo
	with the 3a or 28a	Funeral Director	10e. Street and Number 1323 BURLEIGH ROAD	10f. Zip Code 21093	10g. Citizen of What Country? U. S. A.
920	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "natural", or iteme 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at	þ	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes XVX 1 Yes XVX Year or Dates:	. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, e	s or No- lack, White, etc. 14. Race - American Indian, Black, White, etc. Specify: WHITE
21215-0036	filed within 72 hc Hygiene. bther then "naturent, the Medical	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of working DO NOT use retired) HANICAL ENGINEER & OWN	
Maryland	should be filed and Mental Hygis marked other umatic event.	To Be (17. Father's Name (First, Middle, Last) GEORGE F. ENSOR	18. Mother's Name (First, I	•
Mary	nd 2 sho alth and h 27 is ma ir trauma	1		ling Address (Street and Number or Rural Route BURLEIGH ROAD, LUTHERV	
Baltimore,	permit. Pages 1 and 3 Depurtment of Health Impurtant: If Item 27 any injury or other tr		20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition Commetery, or LORRAINE		20c. Location - City or Town, State WOODLAWN, MARYLAND
Balt	Deportition of the control of the co		R. H. Kein (R. G.RUTH)		1050 YORK ROAD ME,INC. TOWSON,MD.21204
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):	sis	Onset and Death
P.O. Box 68760,	res that the death certificate be executed signed by the attending physicien and be detached for use as the burial-transit	Physician/Medical E	d. IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
	requires tha een signed I nould be det	d by P	Part II. Dther significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 236	e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
al Records,	The law ate has by page 2 st	Completed by			a. Was an autopsy performed? Yes XXNo 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Division of Vital	ding Phys	Certification: To Be	25. Was case referred to medical examiner? 1 Yes XX No 27. Manner of Death XX Natural 5 Pending investigation 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time Injury (Month, Day Year) 28b. Place of Injury At home, farm, suiciding, etc. (Specify)	of 28c. Injury at Work? M 1 Yes 2 No 28d. Des	X Residence 6 □ Other (Specify) scribe how injury occurred sation (Street and Number or Rural Route Number, or Town, State)
_	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical Ce	29a. Certifier (Check only one) 29a (Certifying Physician: To the bast of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, and due investigation, in my opinion, death occurred at the	to the cause(s) and manner as stated. e time, date and place, and due to the cause(s)
	To the To the comple	Mec	29b. Signature and title of certifier A Henkling	VG 29c. License number	29d. Date signed (Month, Day, Year) APRIL 20, 2006
(e Y		30. Name and address of person who completed cause of death (Item 23a) (Type PAUL SCHWARTZ, M.D. 3512 Nec	New 1 Pro- 217	18
	St. Regist	- 2	31. Date filed (Month, Day, Year) APR 2 4 2006 32. Resistrar's Signature	Spale	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | 1 - State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death , ^{Day} 2006 April **Physician** 23, 6:30 P^{M} Herman Frederick Frei /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Middle River Ivy Hall Geriatric Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** XM 2 F Director 214-20-6029 80 Feb. 16,1926 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23s or 28s-f ahow the Modical Examinar must be notified at 1 ☐ Yes 2 No Director Baltimore Middle River Maryland | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 1 Kerria Lane U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Maritat Status Black, White, etc. Pages 1 and 2 should be illed within 72 hours after of health and Mental Hygiene.
ant: if item 27 is marked other than "natural", or lite, any or other traumatic avent, its Musical Examinatory or other traumatic avent, its Musical Examination. No 1944-1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes No Specify: Specify: 3 Widowed 4 Divorced 1946 Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Fireman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Theresa Garmatz Henry Frei ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Kerria Lane, Baltimore, Maryland 21220 Mildred Frei (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: if it any injury or conce. 1
☐Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gard. April 27,2006 Baltimore, Maryland 22. Name and Address of Eachlity Bruzdzinski Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part. Epid the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Demen tra 5 Years **Physician** /Medical Examiner Sequentially list conditions, if any, learning to infinitional cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequent Be Completed by Physician/Medical Examiner attending physicien and for use as the burial-transit Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate 1∐ Yes 2016 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No After this c 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: 5 Pending death. investigation 2 Accident Diractor; 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital c within 24 hours af To the Funeral D completely filled is Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) huks Eso, D0061907 M.D. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1124 Mace Bultmore Avenue

DHMH 17 Rev 1/2001

Registrar

-hukwuma 31. Date filed (Month, Day, Year)

APR 2 4 2006

32. Pegistrar's Signature

				For State Registrar		State o	f Marylar		artment o		ealth and N Death		giene Reg. No.	06	126	94
				1. Decedent's Name (First,	Middle, L	.ast)						2. Date of De Month	ath Day	Year	3. Time o	of Death
	Н	Physicia /Medic		Lois Ruth F	ritz							April	21,	2006	3:52	Ам
		Examin		4a. Facility Name (If not ins Upper Chesape	_					own, or 1 A:	Location of Death ${ m i} r$		4c. (County of Death Harfo		
		Funeral		5. Social Security Number	6.	Sex	7. Age (In yrs.	last birthday)	If Under 1		If Under 24 Hrs.	8. Date of Bir (Month, Da	th V Vear	9. Birth	place (State	or Foreign
5	b	Director		191 14 7328		1 □ M 2 X F	83	Yrs.	Months [Days	Hours Min.	Feb. 23			sylvar	
3		pu 🛾 🕽		Usual Residence of Decedo			10c Ci	ty, Town or Lo	ocation						10d. Inside C	
d		sho	ŭ		-			iddle								s 2X No
10		28a-f	ect	Maryland Ba	ltima	ore	1.	ituate	10f. Zip Ci	ode			10a Citiz	en of What Cou	intry?	
35		Mith Libe	ă	28 Hydropla	ne Di	rive				122	0		-	USA	,	
O		ours after death with the Maryland ral', or items 23a or 28a-f show Exaciliter rivial be notified at	Funeral Director	11. Marital Status		12. Was Dec	edent Ever in U	J.S. 13.			spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No		4. Race - Amer		
	9	or ite	Ē	1 Never Married 2	Married	Armed Fo	2 X No		if Yes, specify 1 ☐ Yes 212			Hican, etc.)		Black, White " <i>Specify:W</i> hi		
9	5-0036	hours after tural', or Ite	d by	3 ⊠ Widowed 4 □ Div	rorced	If Yes, Gir Year or D	ve lates:		1 Tes 22	Z1 140	эрөспу.			Specify: VVIII	LE .	
90/re	2	72 hours "natural", adical Exa	Completed	15. De (Specify only	cedent's highest g	Education grade completed)		16a. Dece (Give	dent's Usual (occupa done d	ation <i>luring m</i> ost of worl)	king	16b. Kin	d of Business/I	ndustry	
त	2121		dm	Elementary/Secondary (0)-12)	College (1-4or 5+)		uction				Tele	communi	.catior	ns
-		be filed within 72 ho tal Hygiene. In other than "natur svent, ine Medical	CO	17. Father's Name (First, N	liddle, La	st)		1100	ac cron		18. Mother's Nam	ө (First, Middle	, Maiden :	Sumame)		
` .	an	2 should be filed withir and Mental Hygiene. Is marked other than raumatic svent, the Mi	To Be	Otto Nitz							Leatha 1	Yohey				
	ary	shou and M a mar umat		19a. Informant's Name/Re	ationship	(Type, Print)			-		and Number or Ru		-			
	Σ	and 2 alth a 127 to		Barbara Shep	herd	(Daught	er)	12435	Wolbe:	rt 1	Way King	sville,	Mary	land 21	087	
	ore	of He of He f item		20a. Method of Disposition 1 XBurial 2 ☐ Crem	ation 3	□ Removal from	0	Place of Dispo cemetery, cre	matory or othe	er place	9)	Date		ation - City or 1		
	Ĕ	Pag Iment tant: I		4 □ Donation 5 □ Ot	her (Spe	cify)	Ma	_			Cemetery					
1	Baltimore, Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic so once.		21. Signature of Funeral S	Brvicerbic	wikows	ke	B 1	ruzdzi 1407 Ol	nsk d E	i Funera astern A	l Home l venue E	P.A. ssex,	Maryla	nd 212	221
	П			23a Part1. Enter the disease shock, or heart failure	ase, or co a. List on	mplications that of by one cause on e	caused the dea each line.	th. Do not en	ter the mode of	of dying	g, such as cardiac	or respiratory a	rrest,		Approxima Interval Be Onset and	etwe <i>e</i> n
	12	Physician		Immediate Cause (Final disease or condition	93	_a a	cute	myo	courd:	al	15cl	remic	~		Oriset and	I Death
, d		/Medical Examiner		resulting in death)		Due to	(or as a consec									
9869180			<u>.</u>	Sequentially list conditions		b. Due to	(or as a consec	suance off:	17-1							
52		uted Insit	Examiner	Sequentially list conditions in any, leading to immediate cause. Enter Underlying Cause (Disease or injury	· ~			,								
1/	Ć,	exection and ial-tra	Еха	that initiated events resulting in death) Last		c Due to	(or as a conse	quence of):				-				
3	Box 68760	law requires that the death certificate be executed as been signed by the attanding physicien and 2 should be detached for use as the burial-transit	cal		•	d. =====										
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#	O.	that the death certific ed by the attanding p detached for use as	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4∐Pregr 9⊡Unkn	nant at time of a own	death 5[Other (spec	rify)					,	
5	σ.	es that thigned by		Part II. Other significant c	onditions	contributing to d	eath but not re	sulting in the u	inderlying cau	ıse give	en in Part I.	23e. Did t	obacco us	se contribute to	the cause of	death?
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9		Physician: this certificantal director,	ToE	examiner? 1 Yes 2 A		Hospital: 1 🖃	thpatient 2	ER/Outpatie	nt 3 DOA	Othe	er: 4 🗆 Nursing H	ome 5□Resi	dence 6	□Other (Spec	ify)	
	n of	ding Ph h. After thi funeral		27. Manner of Death 1 Natural 5 □	Pending	28a. Date (Mor	of Injury hth, Day Year)	28b. Time of Injury		c. Injury Work		28d. Describe	how injury	occurred		
N	ivision	Attending r death. ector: After y the fune	catl	2 Accident	investigat Could not	ho			М		Yes 2□No	001 1				
+	DIX	of or At	Certification:		determine	ad 28e. Place	of Injury - At h ling, etc. <i>(Spec</i>	nome, farm, st ify)	reet, factory, o	office		28f. Location (City or To		l Number or Ru	al Route Nui	mb e r,
1		To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier 1 Check only 2 M	ertifying edical Ex	aminer: On the b	e best of my kn pasis of examin liner stated.	owledge, dea ation and/or in	th occurred at ovestigation, in	the tim	e, date and place pinion, death occu	, and due to the rred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause	(s)
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		200		> non	us	0	-0 -		1	4 C	0631	38	U	21/06		
		6		30. Name and address of	person wh	no completed cau	se of death (Ite		Print)		0631) /	+	200	1	
				Jeffrey 1. S	wet	t, D.g. J	00 Up	per C	hosapa	2ak	eDr. 6	sel 4	C, Γ	110 2	1014	
	×	Sta Registr		31. Date filed (Month, Day		4 2006 J	Registrar's Sign	ature	Anorth 1							

		-	For State Registrar	State of M	faryland / I		ment of Ho ficate of E		l Mental H	ygiene Reg. No.	006	12695
	Dhuaisia		1. Decedent's Name (First, Middle, Las						2. Date of I	Day	Year	3. Time of Death
	Physicia /Medic	al -			Guy				April	. 20,	2006	9:00pm M
di.	Examin	er	4a. Facility Name (If not institution, give Fairhaven Health			41	b. City, Town, or Sykesvi		ath		County of Deal	
	Funeral Director		5. Social Security Number 6. S 047-30-1708	1	ige (In yrs. last bi 87		f Under 1 Year Ionths Days	If Under 24 H Hours M	in. (Month.	Birth Day, Year) , 1919	9. Birt	hplace (State or Foreign nuntry) NC
	and w	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	vn or Locati	ion					10d. Inside City Limits
	Marylé f sho	5	MD Carro	11		5	Sykesvil	le				1 □ Yes 2 💢 No
	with the Na or 28a-	Direct	10e. Street and Number 7200 Third Avenu				10f. Zip Code 217			10g. Citiz	ten of What Co USA	ountry?
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants: If item 27 is marked other than "natural", or items 23a or 28a-f show importants: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be nutified at ODGE.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1 Yes 2 If Yes, Give A Year or Dates	s?] No		s Decedent of Hises, specify Cubar	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or erto Rican, etc.)		4. Race - Ame Black, Whit Specify:	
9	72 ho	ted	15. Decedent's Ec	fucation	168	. Deceden	t's Usual Occupa d of work done d	tion uring most of v	vorkina	16b. Kin	nd of Business	Industry
Maryland 21215-0036	within 7	mple	Elementary/Secondary (0-12)	College (1-40	r 5+)	life. DO	NOT use retired) Teacher		9		Educati	.on
d 2	illed v	a)	17. Father's Name (First, Middle, Last)					18. Mother's N	lame (First, Midd		Sumame)	
/lan	Menta Menta arked atic ev	To B	Sherman Boone						hodil We			
Mar	12 sho h and 7 Is mu trauma		19a. Informant's Name/Relationship (Mrs. Vernice Buel						Rural Route Num ilver Sp			
ē,	Healt tem 2	1	20a. Method of Disposition		20b. Place	of Disposition	on (Name of ory or other place		Date		cation - City or	
E C	Pages net of int: If I		1 ☐ Burial 2 🕅 Cremation 3 ☐ • 4 ☐ Donation 5 ☐ Other (Specif		A		Cremati		22/2006	Syk	esville	e, MD
Baltimore,	permit. Departn Imports any inju		21. Signature of Funeral Service Licer	House		HA Sv	ame and Addres IGHT FUN kesville	s of Facility IERAL H	OME & CH 1784 (41	IAPEL,	PA (Bos 5-1400	195)
8760,	Physician and physician and physician and ithe british and the	dicai Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a	as a consequence as a consequence as a consequence	11 5 CEA 9 of):	lar A	/	,			Interval Between Onset and Death
.O. Box 68	death certifi e attending id for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknowh		2 Fetal deat at time of death		ctopic pregnancy other (specify)			_ 2	3d. Date of de Month	livery Day Year
Δ.	requires that the een signed by th hould be detache	by Ph	Part II. Other significant conditions	contributing to death	but not resulting	in the unde	erlying cause give	n in Part I.				the cause of death?
ord	w require been si should I								24a. W		7	robably 4 Unknown
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Vital	cian: ertific ector,	Be	25. Was case referred to medical examiner?	Hospital:			Othe		Death (Check on			
n of \	ng Phy: fter this ineral d	on; To	1 Yes 2 Q No 27. Manner of Death 1 Natural 5 Pending	28a. Date of II		Outpatient Time of Injury	28c. Injury Work	at ?	g Home 5 Re 28d. Describ			cify)
Division of	or Attenditer deatl	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	e 28e. Place of	Injury - At home, etc. (Specify)	farm, street		/es 2 □ No	28f. Location City or	(Street and Town, State)	d Number or R	ural Route Number,
	Hospital 24 hours a Funeral I etely filled	Medical C	29a. Certifier 1 Sertifying Pl (Check only one) Medical Exe	nysician: To the be miner: On the basis and manner	of examination a	ge, death o and/or inves	ccurred at the tim stigation, in my or	e, date and pl pinion, death o	ace, and due to t courred at the tim	ne cause(s) e, date and	and manner a place, and du	s stated. e to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and ittle of continer	7./			29c. License	number		29d. Date	e signed (Mon	h, Day, Year)
	/		> VIII I	the my			D	po 58	137	4	121/2	006
	15		30. Name and address of person who	295	Store	(Type, Pri	int) o 5430	7 4	lestanins	fer	mo	21157
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 2 4 7	1006 32 degi	strar's Signature	500	de					

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Registrar

APR 2 4

2006

			Please 7	Type or Print	in Black I	ndelible Ink.	Ensure All	Copies A	Are Legib	le.
			1 - State Registrar	State of Mai		partment of Hertificate of L		_	iene () ()	6 12697
	Physicia	an	1. Decedent's Name (First, Middle, Last					Date of Death Month	Day	3. Time of Death
1	/Medic	al	Lorraine B.		on	45 Oir T		<u>pril</u>	10 200	
1	Examin	er	4a. Facility Name (If not institution, give		-	4b. City, Town, or			4c. County o	
			Shady Grove Advent			Rockvil		Data of Righ	Montgo	
	Funeral		5. Social Security Number 6. Se	TM 2□F	(In yrs. last birthda Yrs.	Months Days	Hours Min.	. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
	Director	}	250-57-3575 Usual Residence of Decedent	X	51 415.		Ma	irch 26	,1955 <u> </u>	Bangladesh
	and *	}	10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	sho	'n	Maryland Montgome	. 2017	Montrom	own Willow				1 ☐ Yes 2 ☐ No
	Ba-f	Sct		EL y	Montgom	ery Villag	<u>e</u>		2- 011	Λ
	within 72 hours after death with the Maryland one. one. Than "natural", or items 23a or 28a-f show the Medical Exercities in mail the notified at	by Funeral Director	10e. Street and Number			10f. Zip Code			og. Citizen of Wi	iat Country?
	ath v	<u>a</u>	18205 Lost Knife		303	20886			USA	
	ems Fr	ıne	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S.	 Was Decedent of Hill If Yes, specify Cubar 	spanic Origin? (Speci: n, Mexican, Puerto Ri	fy Yes or No- can, etc.)		- American Indian, White, etc.
98	or it	Ę.	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give	•	1 ☐ Yes 2 No	Specify:		Specify:	Asian
Ö	ura!',	q p	3 ☐ Widowed 4 反 Divorced	Year or Dates:		<u> </u>				
21215-0036	72 h	Completed	15. Decedent's Ed (Specify only highest grad	ucation de <i>completed)</i>	(Gi	cedent's Usual Occupa ve kind of work done o	uring most of working		16b. Kind of Bus	iness/Industry
2	ithin De.	du	Elementary/Secondary (0-12)	College (1-4or 5+)	. DO NOT use retired,			1 1 D	1-
2	ygier ygier ft.	S	12			Program As			World Ba	
P	d off	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name (i		Maiden Sumame	,
<u>×</u>	Men	Ţ	Terence Barlow				Sybil Ba			
Maryland	and and ls m	0.0	19a. Informant's Name/Relationship (7		19b. Ma	iling Address (Street a	nd Number or Rural F	Route Number,	City or Town, S	tate, Zip Code)
2	and Balth n 27	١,	Romayne Pereira/Co	ousin		3 Kentland				
Sec	of H roth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Damoval from State	20b. Place of Dis	position (Name of rematory or other place	Dat	e 2	20c. Location - C	ity or Town, State
Ĕ	Pag nent ant: I		4 Denation 5 Other (Specify		Metropol	Litan Crema	atory 4/2	4/06 A	1exandr	ia, Va.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked a there is natural; or items 23a or 28a-f show any injury or other traumatic svent, the Medical Exercipar must be rediffied at angle.		21 Signature of Funeral Service Libert	see		22. Name and Addres	s of Facility	771		
m	Perm Imp any		(mald X)	NAVA	/	755 Castle	r Funeral (vandria	.Va. 22315
		an or	23a, Part1. Enter the disease, pr comp	lications that caused t	he death. Do not e	enter the mode of dying	g, such as cardiac or r	espiratory arre	est,	Approximate Interval Between
	Dhysisian		shock, or heart failure. List only of Immediate Cause (Final	1		0011 5011				Onset and Death
1	Physician /Medical		disease or condition resulting in death)	a. ACUTE K	ESPIKA7	ORY FHILI	DRE			
	Examiner					nix nese				
		<u>-</u>	Sequentially list conditions,	b. RESPIRA Due to (or as a	consequence of):	100313				
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury				20001			
_	e executed ien and urial-transit	xar	that initiated events resulting in death) Last	c. METASTI Due to (or as a	consequence of):	E10 MYOSA	RCOMH			
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9.	equires that the de sen signed by the rould be detached	F.	Part II. Other significant conditions co	notributing to death but	not resulting in the	underlying cause give	en in Part f	23e. Did tob	acco use contrib	oute to the cause of death?
s,	89 G 9	ρ	, and an analysis of the second secon	Anti-outing to document		andonying sasso give		1 □ Ye		B ☐ Probably 4 ☐ Unknown
Records,	w requir been si should	Completed						1,10	2 2 2010	
Ö	2 8 2	ple						24a. Was ar autops	v 1 pr	ere autopsy findings available for to completion of cause of
	The ste h	Š						perform	ned? de	ath? □Yes 2□No
Vital	ysician: The lis certificate he director, page	Be (25. Was case referred to medical				26. Place of Death (Check only on	9)	
>	Physiclan: this certific ral director,	70 6	examiner? 1 ☐ Yes 2 X No	Hospital: 1 X Inpatien	t 2 ER/Outpat	ient 3 DOA Othe	er: 4 🗆 Nursing Home	5 Reside	nce 6 Other	(Specify)
of	ding Phys h. After this funeral dir		27. Manner of Death	28a. Date of Injury (Month, Day	Year) 28b. Time	of 28c Injury	at 28	d. Describe ho	w injury occurre	d
<u>Ö</u>	nding ath. r: After e fune	읉	1 Natural 5 ☐ Pending 2 ☐ Accident investigation				Yes 2 □ No			
Division	Atte	€	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	286. Place of Infur		street, factory, office	28	f. Location (St. City or Town	reet and Numbe	r or Rural Route Number,
ā	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	- Li riomodo	building, etc.	(Specify)			Only of TOWN	, July	
	hours a meral (29a. Certifier 1 Certifying Phy	ysician: To the best of	my knowledge, de	ath occurred at the tim	ne, date and place, an	d due to the ca	use(s) and man	ner as stated.
	ne Ho n 24 l ne Fu	edical	(Check only 2 Medical Examone)	iner: On the basis of e and manner state		investigation, in my op	oinion, death occurred	at the time, da	ate and place, ar	nd due to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	. 11 -4		29c. License	number		-	(Month, Day, Year)
	0		> Heca	J. Mist	y MI	DS	9738	1	tpril 1	3,2006

Registrar
DHMH 17 Rev 1/2001

State

Alicia T. Mistry, 9901 Medical Center Dr., Rockville, Md. 20850

31. Date filed (Month, Day, Year)

APR 2 4 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Jacobs 2:29 P.M Mary 0 doch /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Mt. Air House HOSPICE Frederick 9. Birthplace (State or Foreign Country) Washington, DC 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex **Funeral** Days Year 1□ M 2X F 214-48-5260 59 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County in then "naturel", or items 23a or 28a-f show the Medical Exercitive must be notified at 1 ☐ Yes 2 XNo New Market Directo Maryland | Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21774 6860 Whistling Swan Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after 0 Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "naturel", or Iten any injury or other treumatic event, the Medical Exercities once. 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cleaning Store Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lawrence Franklin Weed Catherine Beatrice Whalen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Jacobs 6860 Whistling Swan Way; New Market, MD 21774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Falls Church, VA National Crematory * 4 □Donation 5 □ Other (Specify) 4/24/06 22. Name and Address of Facility terling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licensee 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OCARDIAL ISCHEMIC **Physician** /Medical **Examiner** Moul Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed for use as the burial transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) completely filled in by the funeral director, page 2 should be detached 9 Unknown been signed by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Medical Certification; To Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an has autopsy 2 No this certificate 1 ☐ Yes or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 2 No Other (Specify) HOSPICE 1 🗌 Yes Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick ohnson 31. Date filed (Month, Day, Year) . Registrar's Signature State APR 2 4 2006 Registrar

DHMH 17 Rev 1/2001

		,	1 - For State Registrar	of Maryland		artment of H			giene	6	269	9
N		12	Decedent's Name (First, Middle, Last)					2. Date of Dea	t la		. Time of [Death
	Physici /Medio	_	ODESSA M.	JEGGIES				Month	Day 7	Year 7	56	AM
	Examir		4a. Facility Name (If not institution, give street and	. 1		4b. City, Town, or	Location of Deat	h	4c. County			
		AN TO SERVICE	0,01	HUSGITAL		macmi	4 PARIC			J.GO.		Y
	Funeral		5. Social Security Number 6. Sex 1 M 2 M	7. Age (In yrs. las	s <i>t birthday):</i> Yrs.	Months Days	If Under 24 Hrs Hours Min.		5 ^{Yea} 1916	9. Birthplace Nash	(State or TN	Foreign
	Director		Usual Residence of Decedent					ounc 1	3,1710	nabit,		
	yland		10a. State 10b. County		Town or Lo					10d.	Inside City	/ Limits
	e Mai	ctor	Maryland Prince George	's Hy	attsv:	ille					1 Yes	XXNo
	or 28	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of V			
	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or Items 23a or 28e-f show ant, the Modical Exemination multiple multified at	rai	5861 Queens Chape		40.1	W D de - t - t II		S	United			
	ltem Item	Funerai	Ame	Decedent Ever in U.S d Forces? es 2 XXX No	. 13.	Was Decedent of Hi f Yes, specify Cuba	n, Mexican, Puer	to Rican, etc.)		e - American I k, White, etc.	indian,	
920	urs af	by	If Yes	, Give or Dates:		1□Yes XXNo	Specify:		Specify	Black	c	
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Ž	should nd Me mark matic	2	19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address (Street a				State, Zip Co	de)	
<u>≅</u>	nd 2 state at 12 s		Oren Jeffries (SON)			Seminary						041
re,	of Heal		20a. Method of Disposition	20b. Pla	ce of Dispo	sition (Name of natory or other plac	April 2	27°ate 2006	20c. Location -	City or Town,	State	1
E	Page nent c int: If		XX Burial 2 ☐ Cremation 3 ☐ Removal fr 4 ☐ Donation 5 ☐ Other (Specify)	UIII State		armel Cem			Blains	ville.	Virg	inia
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Modical Examinational By notified at ODGe.		21. Signature of Funeral Service Licensee		22	. Name and Addres	ss of Facility Le	e Funera	1 Home,	Inc.	5633	01d
<u></u>	40 E E 8		espectia A Torce	2 MG 145	7	Alexandri	a Ferry	Road, C	linton.	MD 20	0735	17
			23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause	nat caused the death. on each line.	Do not ent	er the mode of dyin	g, such as cardia	c or respiratory ari	rest,	Int	proximate erval Betwiset and Di	reen
	Physician		Immediate Cause (Final disease or condition resulting in death)	lmorary o	ele	me/						
П	/Medical Examiner		Due	to (or as a conseque	ence of):							
8	- t-	e.		to (or as a conseque	ence of):							
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
ó	cate be executed physician and the burial-transit		and thing in denth I not	to (or as a conseque	ince of):							
8760,	ate be hysici	dicai	d									
9	death certifica attending pt for use as t	Mec	IF FEMALE:									
Box	ath coattend	lan/	in the past 12 months?	, outcome of pregnand ve birth 2 ☐ Fetal o	leath 3	Ectopic pregnancy			23d. Dat Mor	e of delivery oth Day	/ Ye	ear
Р. О.	the de	Physician/Med		regnant at time of dea nknown	itn 5L	Other (specify)						
٣.	The law requires that the death certific tte has been signed by the attending p tage 2 should be detached for use as		Part II. Other significant conditions contributing	to death but not result	ting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use conti	ibute to the ca	ause of de	ath?
rds,	quires n sign	d by	HYPERTEN SLOW					1 🗆 Y	es 2 🗆 No	3 Probably	4 🖼	iknown
000	s been si should	Completed						24a. Was a	an 24b. V	Vere autopsy prior to comple	findings a	vailable
Vital Record	Physician: The lavithis certificate has al director, page 2	E O						autop perfor 1 Yes	med?	rior to comple leath? Yes 2		use of
ita	ian: ortifica ctor, p	Bec	25. Was case referred to medical examiner?		/		26. Place of De	ath (Check only or				
×	Physician: r this certific ral director,	ပ္	1 ☐ Yes 2 ☐ No ☐ Hospital: 1		R/Outpatier		4 🗆 140151119 1	Home 5 ☐ Resid				
Division of	ing P	Certification:	1 Natural 5 ☐ Pending	ate of Injury Month, Day Year)	28b. Time of Injury	Worl		28d. Describe h	ow injury occurr	ed		
isi	Attending r death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	lace of Injury - At hom	no form etc		Yes 2 No	28f. Location (S	treet and Numb	ar or Qural Do	uto Numb	101
<u>></u>	after Direction by	ertif	4 Homicide determined	uilding, etc. (Specify)	10, 121111, 511	eet, factory, office		City or Tow		er or ribrai ric	iute ivainib	91,
_	Hospital 24 hours a Funeral C		29a. Certifier 1 Certifying Physician: To	the best of my know	ledge, deatl	occurred at the tim	ne, date and place	e, and due to the o	ause(s) and ma	nner as stated	d.	
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai	(Check only 2 Medical Examiner: On the	ne basis of examination manner stated.	on and/or in	vestigation, in my of	pinion, death occ	urred at the time, o	date and place, a	and due to the	cause(s)	
	To the within 2 To the complet	M	29b. Signature and title of certifier			29c. License	e number	i	29d. Date signed	(Month, Day	, Year)	
	1		(Carildon Car	~D		35-	127		04-	19-2	006	
Ì	0		30 Name and address of person who completed	cause of death (Item 2	23a) (Type,	Print)		5	2	10.0		
	X.	100	31. Date filed (Month, Day, Year) 3	2. Signatura's Signatur	PARAC	IND	· JM	181	NUNM	, vu)	
1000	Sta Regist		APR 2 4 2006		4	antis	•					
DI	MH 17 Bev 1/2		2 2000	CHARLES A	17							

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar Inval be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physicien end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

1 - For State Registrar	State of Ivial	-	Pertifica				leg. No.	06	12700
Decedent's Name (First, Middle, Last LOUIS	st)		JAND0	RF		2. Date of Dea	19 ^{pay} 20	06 ^{ear}	3. Time of Death 2:20 P M
4a. Facility Name (If not institution, give 5733 PIMLICO ROA			4b. Cit	y, Town, or L	ocation of Dea	ath IMORE	4c. Coun	ty of Death	/A
5. Social Security Number 6. S 213-01-1847	ex 7. Age (In yrs. last birtho	Month	er 1 Year S Days	If Under 24 Hi Hours Mii		, 1916	9. Birthi Cou	place (State or Foreign ntry) MD
Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town o							10d. Inside City Limits
MD N/A		В	ALTIMO	JKE Lip Code			10g. Citizen of	What Cou	1 No Yes 2 No
5733 PIMLICO RO	ΔD		101. 2	.ip 0000	2120		rog. Onizoti ol	Wildle Ood	USA
11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Dec	edent of Hisp ecify Cuban,		(Specify Yes or No- erto Rican, etc.)	14. Ra BI	ace - Ameri ack, White,	can Indian,
1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates:		1 🗆 Yes		Specity:		Spec		WHITE
15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a. D	ecedent's Us Give kind of v ife. DO NOT	ual Occupati vork done du use retired)	on ring most of w	vorking	16b. Kind of	Business/Ir	dustry
Elementary/Secondary (0-12)	College (1-4or 5+)	OWN		400 / 011/00/			JANDOR	RF ELF	ECTRIC
17. Father's Name (First, Middle, Last)				1		ame (First, Middle,	Maiden Suma	ame)	
LOUIS		JANDO	RF, SF	₹.	EST	ELLE			STRAUSS
19a. Informant's Name/Relationship (-			Rural Route Numbe			
SUSAN TAYLOR / 20a. Method of Disposition		and the second second				E - BALTII	MUKE, I		
1 🕅 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Hemoval from State	20b. Place of D cemetery, BALTIMO	-		EM 04,	/21/2006	REIS	STERS	TOWN, MD
21. Sometry of Funeral Service Light	wen			and Address REIST		SOL LEVIN N ROAD -			, INC. MD 21208
23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition		aton				ac or respiratory an	rest,		Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a control of the contr	Consequence of)	L I:						>5 year
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal death	3 ☐Ectopic 5 ☐ Other (Date of delive	rery Day Year
Part II. Other significant conditions of		1 1	he underlying	cause giver	in Part I.		bacco use co		the cause of death?
-						24a. Was autop perfor 1 □ Yes	rmed)	o. Were autoprior to condeath?	opsy findings available ompletion of cause of
25. Was case referred to medical examiner?						eath (Check only o			
1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pending	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day)		ne of	28c. Injury a	4 Nursing	Home 5 Resid	lence 6 🗆 C		fy)
2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	e One Place of Injur	/ - At home, farm	М	1 🗆 Y	es 2 🗆 No	28f. Location (5 City or Tow	Street and Nur vn, State)	mber or Rui	al Route Number,
(Check only 2 Medical Exar	nysician: To the best of miner: On the basis of e	xamination and/							
29b. Signature and title of certifier	and manner state	IU.	2	9c. License	number \	EDISKOD 3	29d. Date sign	ned (Month	, Day, Year)
1 hang 66 6	ians		7	0260	93	1720-7	4/20	106	
30. Name and address of person who	completed cause of dea	th (Item 23a) (T	ype, Print)						

State Registrar Dana H. Frank

10755 Falls Rd. Suite 200 Lutherville, Md 21093

06-02700 Charles Knorr

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Medical Examiner CHARLES ALAN KNORR 0920 hrs April 21, 2006 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 310 North Chapelgate Lane Apt K n/a 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) **Funeral** oreign Director Months Days Hours Min 1XXM 2 F 218-22-3112 79 Feb. 15,1927 Country) Maryland Usual Residence of Decedent 'n 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Baltimore 1XX Yes 2 No Maryland n/a ges I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f sho Director Street and Number North 10f. Zip Code 10g Citizen of What Country 310 Chapelgate Lane Apt. 21229 U.S.A. Funeral 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? White, etc. 1 Never Married 2 Married Yes ХX Yes, Give Year Widowed Divorced Yes 2XX No specify Specify: White \$ or Dates: 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 the Medica 4 Accountant Chemical Company 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Mary matic event, Be Al an Knorr Rosendale 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Codd (Nephew) 1007 Jamieson Road Lutherville, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State or other 1XX Burial 2 Cremation 3 Removal from State crematory or other place) artment o Baltimore, Maryland 6500York Road Cathedral Cemt. 4-25-06 Donation 5 Other Specify 22. Name and Address of Facility Starsature of Funeral Service Licens Mitchell-Wiedefeld F.H. Inc. Baltimore, Md. Colver 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Approximate Interval Between Onset and /Medical Death a Head Injury Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical UNPENDED AMENDED Box 68760, ending phy: use as the b 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Dav Year past 12 months? 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? ò Atherosclerotic Cardiovascular Disease 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a Was an 24b. Were autopsy findings available MEMAL DISEASE autopsy prior to completion of cause of performed? death? ✓ Yes Yes 2 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other₄ this Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other Scene 1 🗸 Yes ۵ 28a. Date of Injury FOUND: After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural FOLIND 5 Pending 1 Yes 2 ✔ No Apr 21, 2006 0905 hrs 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) 210 N. Chapelgate Lane Apt K, Baltimore, MD within 24 hours a To the Funeral I determined (Specify) Multi-Family Apt. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started cal 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 22, 2006 30. Name and addless of person who completed cause of death (Item 23a) Deputy Chief Medical Examiner Jack Titus MD. 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month APR 2 4 2006 State 32. Registrar's Signature The second Registra

		í	For State Registrar	State of Mar	-	epartment of h			iene	12702
			Decedent's Name (First, Middle, La	ist)				2. Date of Deat	n	3. Time of Death
	Physici		George W. Linder	. Jr.				Month April 1	7, 2006	3:55 P. M
}	/Medio Examin		4a. Facility Name (If not institution, gir			4b. City, Town,	or Location of Death		4c. County of Dea	
			Catonsville Cor	mons		Catons	sville		Balti	more
	Funeral			Sex 7. Age (In yrs. last birth	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bi	rthplace (State or Foreign country)
	Director		220-14-0459	IMM ZUF	82 Y	s.		April 7	, 1924 M	aryland
	and .		Usual Residence of Decedent 10a, State 10b, County	1	I0c. City, Town	or Location				10d. Inside City Limits
	Manyl f sho	ō	Monryland Doltin		Cotor	sville				1 ☐ Yes 2 🙀 No
	28e-	Director	Maryland Baltime	ore	Cator	10f. Zip Code		10	og. Citizen of What C	Country?
	3a or	0	104 Delrey Avenue	2		212	228		USA	307
	death ms 2	Funeral	11. Marital Status	12. Was Decedent Ev	er in U.S.	13. Was Decedent of If Yes, specify Cub		ecify Yes or No-	14. Race - Am	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Evantities mast be ricitlised at 2002e.	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No		mican, etc.)	Specify:	White
O O	72 ho	Completed	15. Decedent's E (Specify only highest gi			Decedent's Usual Occu Give kind of work done		ina	16b. Kind of Busines:	s/Industry
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2	ed wi ygien ygien ygien ygien tr.		12		Co	ntractor	10.14		Plumbing	& Heating
<u>n</u>	be fil tal H d oth	Be	17. Father's Name (First, Middle, Las				18. Mother's Nam			
$\frac{3}{2}$	ould I Men narke natic	은	George W. Linder		405	4-11 4-11 (01	Germaine			To 0 11
Mai	12 sh h and 7 Is n traun		19a. Informant's Name/Relationship Doris Linder	Wife		Mailing Address (Stree			5-07	
Ġ,	1 and Healt em 2		20a. Method of Disposition		20b. Place of I	Delrey Av			20c. Location - City o	
100	ages nt of t: If it		tX Burial 2 ☐ Cremation 3 ['4 ☐ Donation 5 ☐ Other (Spec			crematory or other pla on Cemetery		2006 W	oodlawn,	Marvland
Ē	artme ortan injury	1	21. Signature of Funeral Service Lice		21	,	1			
Ba	Dep lmp any		1/ (mn	Kalh		Funeral H	lome of Ca	tonsvill	hton Schw e,Inc. onsville,	MD 21228
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the	ne death. Do no					Approximate Interval Between
	Pnysician	8 0	Immediate Cause (Final disease or condition	M		which R	al Lat	Co		Onset and Death
	/Medical		resulting in death)	a. Due to (or as a			Jack			147
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687	death certiticate be executed e attending physician and of for use as the burial-transit	dlcal		d						
	eath certitics attending pl	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		_			23d. Date of de	elivery
Вох	death e atte d for	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 4 Pregnant at tir		3 ☐Ectopic pregnand 5 ☐ Other (specify) _	СУ 		Month	Day Year
o.	t the by th	Physician/Me	9 Unknown	9⊡ Unknown						
S,	res that igned by be deta	by P	Part II. Other significant conditions	contributing to dath but	not resulting in	the underlying cause g	ven in Part I.			to the cause of death?
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ecc	has be	Completed						24a. Was ai	v prior to	autopsy findings available completion of cause of
E.		Son						perforn	ned? death?	
Vital Records,	Physicien: The this certiticate ral director, pag	Be	25. Was case referred to medical examiner?					h (Check only on	9)	
	S 0 0	2	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient		patient 3 DOA			nce 6 Other (Sp	ecify)
u c		on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Ti	ury Wo	ork?	28d. Describe ho	w injury occurred	
sio	teat leat tor: the	cati	2 Accident investigate 3 Suicide 6 Could not	he l]Yes 2 □No	20f Location (Ct	reet and Number or F	Zuml Dauta Alumbar
Division of	in the	Certification:	4 Homicide determine		(Specify)	n, street, factory, office	'	City or Town		nurai noble ivumber,
	Hospitel 4 hours a Funeral tely filled		29a. Certifier 1 Certifying F	hysician: To the best of	my knawledge	death occurred at the t	ime date and place.	and due to the ca	use(s) and manner a	as stated.
	24 hos Fun	Medical	(Check only 2 Medical Exe	miner: On the basis of e	xamination and	or investigation, in my	opinion, death occur	red at the time, da	ate and place, and du	ue to the cause(s)
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	Me	29b. Signature and title of certifier	<u></u>	AH	29c. Licen	se number	29	d. Date signed (Mor	nth, Day, Year)
	7		1 / Rupeli	£~~0.	. •/	My Di	36942	,	H11/1/19	, 2006
- 1	2.0		30. Name and address of person who	mpleted cause of dea	ith (Item 23a) (ype, Print)	1 Ra. Ca	Long. 11	9 444	2 (2 - 3
0	7		15. TURAKH	if my	1009	tredery	Ic Kd. Ca	70.37 40	4 1 100	4228
		ate	31. Date filed (Month, Day, Year)	32, Registrar	's Signature'	-1-1				
DU	Regist	-	APR 2 4	2006 10000	J. K.	Good!				
υH	MH 17 Rev 1/2	-00 I	HIII & #	2000	ORIG	INAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** RICHARD LOCKWOOD 04 06 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Franklin Sq uare Center HOS pital If Under 1 Year Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye NOV 18, 6. Sex 1 M 2 ☐ F Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** ,1919 MARYLAND Days Hours 86 216092089 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location r than "natural", or iteme 23e or 28e-f ehow the Medical Examiner must be notified at 10d. Inside City Limits 1 Yes 2 No Director BALTIMORE **ESSEX** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 710 MIDDLESEX ROAD 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WW 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: WHITE Specify: þ 3 ☐ Widowed 4 ☐ Divorced WW II Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **FOREMAN** 10 0 STEEL Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Peges 1 and 2 should be nent of Health and Mental RICHARD LOCKWOOD SR **EMMA** Α. BUEHNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSE E. LOCKWOOD / WIFE 710 MIDDLESEX ROAD ESSEX, MD 21221 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
GARDENS OF FAITH 4/24/06 20a. Method of Disposition 20c. Location - City or Town, State injury or 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Depertment Important: If eny injury or BALTIMORE, MARYLAND 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVENUE BALTIMORE, MD 21237 23a. Part1. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** As piration /Medical Due to (or as a consequence of): Examiner fibrillation Atria Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physicien end s the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as the ettending | for use as 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 ⊡Unknown urgitation 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No reg After this certificete has Cancer head neck 1 ☐ Yes 2 ⊉′No Be 25. Was case referred to medical examiner? 26. Place of Death Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 Tes 2 No To the Funeral Director: completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours e To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) APRIL 21, 2006 162 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Frankin Squar Pa7 Kobert Drive, Baltimore. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State APR 2 4 2006 Registrar DHMH 17 Rev 1/2001

			1 - For State Registrar	State	of Maryla		epartmer Certificat			Mental Hy	giene Reg. No	ll II fa	2704
ı	Physici /Medic		1. Decedent's Name (First, Middle Kendall L. L							2. Date of De Month April	Da	y 2006 ^{Year}	3. Time of Death 8:35 P M
	Examin		4a. Facility Name (If not institution Anne Arundel	Medical	Center		Ar	napo			A	nne Aru	ındel
	Funeral Director		5. Social Security Number 578 88 2976 Usual Residence of Decedent	6. Sex 11√21/M 2 ☐ F	7. Age (In y	6 Yr	Months	Days	Hours Min.		th ay, Year) , 19	9. Bi	rthplace (State or Foreign Sountry) shington DC
	e Maryland 8a-f show illied at	ctor	10a. State 10b. County Maryland Anne	e Arundel	10c.	City, Town o	Edgewa						10d. Inside City Limits
	th with th	Funeral Director	10e. Street and Number 144 Washing	ton Road			10f. Zij	21037	7			tizen of What C ted Sta	•
0000	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Itams 23a or 28a-f show ant, it a Modical Examire matter notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4√Divorced	ned 1XXYe	ecedent Ever in Forces? s 2 ☐ No 1 Give r Dates: 1		13. Was Dece If Yes, spe 1 \(\sum \) Yes	cify Cuban	panic Origin? (§ , Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	0-	14. Race - Am Black, Whi Specify:	
0-6171	within 72 ho	Completed		t's Education st grade complete		16a. D	ecedent's Usu Give kind of wo ife. DO NOT u	ork done du se retired)	ion iring most of wo	orking		ind of Business	·
lana z	ild be filed v lental Hygie kad other i ic evant, IL	To Be Co	17. Father's Name (First, Middle, John F.				ADOI 13t			me (First, Middle	, Maiden	Sumame)	ure
, mary	and 2 shousalth and M n 27 is mar		19a. Informant's Name/Relations Rory M. Lohm			841	13 Thor	nberr		· .			Zip Code) oro, MD20772
Ba ltimore,	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic evant, if a M. Jica Examiter must be milling at once.		`4 ☐Donation 5 ☐ Other (S	Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) April 28, 2006									r Town, State ham, Maryland 6633 Old 20735
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Br Due	latera to (or as a cons	L B equence of)	acter			c or respiratory a			Approximate Interval Between Onset and Death
9/00,	icate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	S c	to (or as a cons								
C. Box a	to the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	outcome of preg e birth 2 Fi egnant at time o known	etal death	3 □Ectopic p 5 □ Other (s)					23d. Date of de Month	blivery Day Year
cords, r	w requires that been signed should be det	by	Part II. Other significant condition	_		_	ne underlying (_	in Part I.				o the cause of death?
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	ha Hospitu in 24 hours ha Funara pletely fille	Medical C	29a. Certifier 1 Certifyir (Check only one) 1 Medical	ng Physician: To s Examiner: On the	the best of my keep basis of exam anner stated.	nowledge, of ination and/o	death occurred or investigation	at the time	n, date and place nion, death occi	e, and due to the urred at the time,	date and	d place, and du	e to the cause(s)
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i	5+5		30. Name and address of person Stephen Olexo.	M.D. 20	01 Medi	cal P	ark, Ar	napo	lis, MD	21401			
	Sta Registr		31. Date filed (Month, Pay Year)	4 2005 32	. Registrar's Sig	mature	Aread	5					

amend State of Maryland / Separtment of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 5:00 am Helen Cecelia Lewis 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner HOSPITA -osedall timore uare 5. So**21 7-07 048**5 If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) 04/24/1916 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 K F Months Davs Hours Min 89 Yrs. Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a State 10d. Inside City Limits 28a-f show or other treumatic event, the Medical Exercises must be notified at 1 Yes 2 □ No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 242 S. Washington Street 21231 United States or Items 23a by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other than any Injury or other treumatic event, If a Megone. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Eleanor Dorsey 9 Ambrose Bauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Aural Aoute Number, City or Town, State, Zip Code) J. Richard Lewis - Son 3408 Glenside Drive Baltimore, Maryland 21234 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cometery, crematory or other place)
Most Holy Redeemer
Cemetery 1

Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/24/2006 Baltimore, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility.
David J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** 6 dai /Medical Due to (or as a consequence of): Examiner MEUMONIO Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): al or Attending Physician: The law requires that the death certificate be executed after death.

Infector: Alter this certificate hes been signed by the attending physicien and in by the tuneral director, page 2 should be detached for use as the burial-Itansit dir by the funeral director, page 2 should be detached for use as the burial-Itansit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? intarc 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? ma 24a. Was an autopsy performed? 2 No 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient Certification: To 3□ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital o within 24 hours aft To the Funerel Dis 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State APR 2 4 2006 Registrar

ewis,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death Rea No 2. Date of Death 1 Decedent's Name (First Middle Last) 3. Time of Death **Physician** APRIL 18 2006 LEIKACH 10:35A M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE JEWISH CONVALESCENT CENTER BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth DEC. 28, 1914 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sax **Funeral** 1 M 2 F Months Days Hours POLAND Yrs 91 Director 213-30-8806 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiane.
Important: if item 27 is marked other than "natural", or iteme 23a or 28e-f show with ijury or other treumatic event, the Macifical Examinat must be notified at once. 10a State 1 ☐ Yes 2 No Director BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 USA 3117 SHELBURNE ROAD Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **PROPRIETOR** GROCERY STORE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be MELAMED LEIKACH RUCHEL DEVORA CHAIM 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3117 SHELBURNE ROAD - BALTIMORE, MD 21208 ANN LEIKACH / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BETH TFILOH CEMETERY 04/21/2006 WOODLAWN, MD 4 ☐ Donation 5 ☐ Other (Specify) of Fimeral Service Liouns 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Part . Enter the disease, or com shock, or heart failure. List only or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner ettending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) cete has been signed by the page 2 should be detached 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No After this certificete funeral director, pag 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Certification: To 1 🗌 Yes 2 € No 1 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 27. Manuar of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident hours efter death unerel Director: the To the ...
within 24 hours c...
To the Funerel Director. 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as slated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at lihe time, date and place, and due to the cause(s) and manner stated. (Check only one)

State

The law requires that the death certificate be executed

P.O.

Division of Vital Records,

Attending Physician:

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

31. Dale fifed (Month, Day, Year) APR 2 4 2006

29b. Signature and title of certifier

2434 32 Agistrar's Signature

30. Name and address of derson who completed cause of death (Item 23a) (Type, Print) 201

29d. Date signed (Month, Day, Year)

Registrar

Please Type or Print in Black Indelible Jak. Ensure All Copies Are Legible. Amend I tem 5 per Th 9855 5-10-06 vt State of Maryland Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Rag. Nő. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 21, 2006 7:01P M MARIE ELLEN WILLIAMS McGINN April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPICE OF BALTIMORE @ GILCHRIST CENTER TOWSON

5. Social Septity Internal 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Baltimore County 5. Social Se07 0906 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1□M 2QF Yrs. Director 220-06-0907- 87 Aug 6, 1918 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits irel', or items 23a or 28a-f ehow Examiner must be notified at 1 ☐ Yes 2 No Maryland | Baltimore County Baltimore Parties Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21212 115 Glen Argyle Road USA filed within 72 hours after death Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 en "naturel", or Medical Exami 1 ☐ Yes 21X No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Banking Accounts Clerk 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thomas J. Williams myrtle I. Bransby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is eny injury or other trau Paul E. McGinn (Husband) 115 Glen Argyle Road, Baltimore, Maryland 21212 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem Grdns 4/26/2006 Timonium, Maryland 21. Signature of Funeral Service Ligens e Aurra Martin D. Lawson 22 Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. Martin D. Lawson

6500 York Road, Paltimore, Maryland

21212

Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulmonery FIBROSIS Physician years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner attending physicien end for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 ponths?
1 Yes 2 No
9 Unknown Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown certificete has been si rector, page 2 should Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 € No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOS Pic Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 2 1 ☐ Yes 2 🔭 No 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 13 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation ofter deat Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funerel [Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 D 28303 APRIL 21 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Amon Curics in 660(N Curics St Barriote in 21204

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Pax, Year) 4 2006

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32 Aggistrar's Signature

12000

			1 – For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of F			giene 0 0 6	; 12708
- K			Decedent's Name (First, Middle, La	st)				2. Date of Dea Month	th	3. Time of Death
	Physici /Medic		WILLIAM	HARRY	Z M	OSS		APRIL	Day Y	ear 1.15 a M
A	Examir		4a. Facility Name (If not institution, given			4b. City, Town, o			4c. County of	Death
		10°	Frederick		~		redericl			ederick
1,000	Funeral Director			Sex 7. Ag	e (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		1914). Birthplace (State or Foreign Gountry) Maryland
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ecation				10d. Inside City Limits
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	the N	rect	10e. Street and Number	LICK		10f. Zip Code	0116		log. Citizen of Wh	
	3a or	<u></u>	11038 Old Frede	erick Road			21788	3	Į	J.S.A.
	death	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H	lispanic Origin?	(Specify Yes or No-		American Indian, White, etc.
36	filed within 72 hours after death with the Maryland Hygiene. ither than "natural", or Itame 23a or 28a-f ahow ither than "natural", or Itame Frust De Foolified at	by Fu	1 Never Married 2XXMarried 3 Widowed 4 Divorced	1 Yes 2 1 If Yes, Give Year or Dates:	1942 to	1 □ Yes 2√√Xio	Specify:	orto riioari, oto.,		White
Ŏ	2 hou	Completed	15. Decedent's E (Specify only highest gr	ducation	16a. Deced	dent's Usual Occup	ation	working	16b. Kind of Busin	ness/Industry
21	ithin 7	npie	Elementary/Secondary (0-12)	College (1-4or 5	iife. i	noruse retirectives	d)		I C Pos	stal Service
2	led w lygier her th		LL (Controlled to 1		Lecte	L Callle		lame (First, Middle,		
land	uld be fi Aental H rked ot tic aver	To Be	17. Father's Name (First, Middle, Last William Henry N					y Harris	Maiden Sumame)	
Maryland 21215-0036	id 2 shoilth and N		19a. Informant's Name/Relationship Richard W. Moss		19b. Mailir 11 038	ng Address (Street Old Fred	and Number or a	Rural Route Number Dad-B, Thu	r, City or Town, Sta	ate, Zip Code) Maryland 21788
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene important: If item 27 Ia marked other than "natural", or Itame 23s or 28s-f ahow amy injury or other traumatic avent, the Medical Examinat must be notified at ance.	713	20a. Method of Disposition 12 Durial 2 Cremation 3 E 4 Donation 5 Other (Speci		20b. Place of Dispo cemetery gree Mount Oliv	sition (Name of matory or other place ret Cemet	ery Apri	Date il 24, 200	20c. Location - Ci	ty or Town, State erick, Marylan
Baltir	permit. P Departme Importan any injur		21. Signatur A Fun, ral Service Lice			Name and Addre	ss of Facility Bas	sford Fune	eral Home	2
19	*		23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused	the death. Do not ent					ck, MD 21701 Approximate
, 1	Physician		Immediate Cause (Final	one cause on each li	ně.	1				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as	a consequence of):	-/V	wyy	nome		
	Examiner			h	, ,	U				
'E	₽ ≅	ner	Sequentially list conditions, any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):					
	ecute and trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c.						
8760,	ficate be executed physician and is the burial-transit	al E		Due to (or as	a consequence of):					
387	phys phys s the	dical		d.						
Division of Vital Records, P.O. Box (The law requires that the death certifi ate has been signed by the attending I page 2 should be detached for use as	Physician/Me	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3]Ectopic pregnancy] Other (specify) _	,		23d. Date o Month	,
oj.	s that t ned by a detai	by Ph	Part II. Other significant conditions	contributing to death b	ut not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribi	ute to the cause of death?
rds	w requires to been signer should be o							1 Y	es 2□No 3	Probably 4 DUnknown
Reco	The law re te has ber age 2 sho	Completed						24a. Was a autops perfor	sy prio	re autopsy findings available or to completion of cause of ath? Yes 2 \(\subseteq \text{No} \)
ta		BeC	25. Was case referred to medical examiner?				26. Place of D	eath (Check only or		7.00 22.110
<u>></u>	Physician: r this certificanal director,	To E	1 Yes 2 No	Hospital: 1 Inpatie	ent 2 ER/Outpatier		4 Nursing	Home 5 ☐ Reside	ence 6 Other	(Specify)
חַ	Jing P	on:	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Inju (Month, Da	ry Year) 28b. Time of Injury	Wor		28d. Describe h	ow injury occurred	
Sio	Attending it death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not to	De Diana et la	At home from the		Yes 2 □No	296 Location (C	troat and Number	os Rusal Route N. — has
Ω	if or Attendated after death Director:	Certification;	4 Homicide determined	building, et	ury - At home, farm, str c. (Specify)	eet, ractory, onice		City or Town		or Rural Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier 1 Certifying P (Check only one)	hysician: To the best miner: On the basis o and manner st	of my knowledge, death f examination and/or in- ated.	h occurred at the tir vestigation, in my o	ne, date and pla pinion, death oc	ice, and due to the c curred at the time, d	ause(s) and mann late and place, and	er as stated. If due to the cause(s)
	To the	Me	29b. Signature and title of pertifier	()		29c. Licens	e number	2	9d. Date signed (I	Month, Day, Year)
	1		· Sn	whom	MD	25	8391		4-2	20-06
	12		30. Name and address of person who Sajjed Aziz, M.	b. 801 To	oll House A	venue C-	3, Frede	erick, Mar	yland 21	.701
京学院	Sta Regist		31. Date filed (Month, Day, Year) APR 2 4	32. egistr	ar's Signature	ade			*	

			1 - For State Registrar	State of		nd / Depa		of He	ealth a		ental Hy		106	c.	270	9
ź.	Physici /Medic		Decedent's Name (First, Middle, I Mary Bar	ası) Bara Macı	um						2. Date of Dea Month April 1	Da	, 2006 ^Y	ear .	3. Time of De 2:15	
	Examin		4a. Fecility Name (If not institution, g 8701 Opossumto		er)		Fre	deri					Frede		ck	
ŀ	Funeral Director		176-20-4088	Sex 7.	Age (In yrs.	last birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min.	8. Date of Bird Jan 2	5^{Year}	L927 I		lace (State or F isylvan:	
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Freder	rick		ty, Town or Lo								1	0d. Inside City I	-
	3a or 28a	Funeral Director	10e. Street and Number 8701 Opossumt	own Pike	1		10f. Zip (Code .702				_	izen of Wha	at Coun	itry?	
2-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mental Hygiene. Department of health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Items 23a or 28a-f show eny injury or other traumatic event, I'm Medical Examination and lifed at ance.	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Yes & If Yes, Give Year or Date	es? ∐ No		Was Decede		panic Orig , Mexican, Specify:	gin? (Spec Puerto F	cify Yes or No- Rican, etc.)		14. Race - Black, 1 Specify: V	White,	etc.	
N-C Z	within 72 ho ane. than "natu	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)		or 5+)	(Give	dent's Usual kind of work DO NOT use ent/Br	k done du e retired)	uring most	of workin	g		ind of Busin		·	
yiang z	lid be filed lental Hygid ked other ilc event, II	To Be Co	17. Father's Name (First, Middle, La C. Gilber	st Hazlett		1	2110, 22		18. Mother		(First, Middle, a Moore	Maiden		Jeac		
Mar	and 2 shou alth and M 27 is man or traumat		19a. Informant's Name/Relationship Mr. Samuel H. Ma		band						Route Number, Frede					
saitimore,	Pages 1 ament of He ent: If Item ury or oth		20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other (Spe		ate	Place of Dispo cemetery, crei unt Olive	matory or oth	her place			2006		ederic	-	_{wn, State} Marylar	nd
Dall	4 Donation 5 Other (Specify) Mount Olivet Cemetery April 20, 2006 Fred 21. Signature of Füheral Service Licensee MOO255 MOO255 MOO255 Mount Olivet Cemetery April 20, 2006 Fred 22. Name and Address of Facility Keeney and Basford PA Funeral 106 East Church St., Frederick											al Hon	ne 21	.701		
	Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final disease or condition			th. Do not ent ratory			, such as o	cardiac or	respiratory ar	rest,			Approximate Interval Betwee Onset and Dea	en ath
	/Medical Examiner	_	resulting in death) Sequentially list conditions,	b	COPD as a consec										5 year	rs
,00,	ate be executed hysician and he burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inhitated events resulting in death) Last	С		ette Sr	noking	5								
O. Box 68	The law requires that the death certifice are has been signed by the attending phage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes ※XXNo 9 ☐ Unknown	23c. If yes, outco 1 ☐ Live birt 4 ☐ Pregnan 9 ☐ Unknow	n 2 ☐ Feta tattime of d	aldeath 3[Ectopic pre						23d. Date o Month		ory Day Yea	ar
ras, r	quires that in signed b uld be deta	þ	Part II. Other significant conditions Bladder		h but not res	sulting in the u	nderlying ca	use giver	n in Part I.						e cause of dea ably 4 □Unk	
Vital Records,	.77 —	Completed									24a. Was autop perfor		prio dea	r to cor th?	psy findings avanpletion of caus	ailable se of
0	ding Phy I. After this funeral d	atlon: To Be	25. Was case referred to medical examiner? 1 Yes XX No 27. Manner of Death XX Natural 5 Pending 2 Accident investigal			ER/Outpatier 28b. Time o Injury		Other	r: 4 □ Nur at	sing Hom	(Check only one 5) (Check only one 6) (Check one 6) (Check	lence		Specify	()	
DIVISION	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Certification:	3 Suicide 6 Could no 4 Homicide determine	286. Place of	Injury - At h , etc. (Speci	nome, farm, str	reet, factory,	office		2	8f. Location (S City or Tow			or Rura	l Route Numbe	r,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edicai	(Check only 2 Medical Ex	Physician: To the beaminer: On the base and manner	s of examina	owledge, deat ation and/or in	vestigation,	in my opi	nion, deat	d place, a h occurre	d at the time, o	date and	f place, and	due to	the cause(s)	
	To Tool	Σ	29b. Signature and title of certifier	irier	ر ر	M, D	• D	License 095					te signed (A		2006	
10				rier, M.D.	, 186	Thoma		son	Dr.,	Free	derick,	Maı	cyland	1 21	.702	
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 4	807	istrar's Sign	ature_	and)									

ORIGINAL

DHMH 17 Rev 1/2001

			For State Registrar	State of M	Maryland / Dep Ce	partment of Fertificate of		and Mental Hy	/giene	6 12710	
*	Dhysis		1. Decedent's Name (First, Middle, Las	t)				2. Date of D Month	eath Day	3. Time of Death	
	Physici /Media	-du	Katherine Mari	e Meyers	3				17, 2006	1540 p	VI
	Examir	1 3	4a. Facility Name (If not institution, give		r)	4b. City, Town, o	r Location o	of Death	4c. County		
	The same	-	2403 Spring Lake			Timoniu		24 Hrs.	Balti		
6,:"	Funeral		5. Social Security Number 6. So	9X 7. A □M 2XX F	Age (In yrs. last birthda) Yrs.	Months Days	Hours	Min. (Month, D	ay, Year)	Birthplace (State or Foreig Country)	дп
	Director		212–10–2767 Usuaf Residence of Decedent		89 ^{Yrs.}			Nov. 1	, 1916	New York	_
	/land		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limit	s
	Mar	to	Maryland	n/a	Balti	more City				1 ☐Yes 2 ☐ N	О
	or 284	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country?	
	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Items 23a or 28a-f ehow event, the Medical Exaturar must be notified at	a D	1604 Wadsworth W	ay		21239			Uni	ited States	
	dea dea	Funeral	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.S. 13	. Was Decedent of H	lispanic Ori	gin? (Specify Yes or N n, Puerto Rican, etc.)		ce - American Indian,	
36	or It		1 Never Married 2 Married	1 ☐ Yes 2 🔀 If Yes, Give	No	1 ☐ Yes 2 X No	Specify:		Specif		
21215-0036	ural',	d by	3 X Widowed 4 □ Divorced	Year or Dates							
5-	"nat	Completed	15. Decedent's Ed (Specify only highest gra		(Giv	edent's Usual Occup re kind of work done . DO NOT use retired	durina mos	t of working	16b. Kind of B	Susiness/Industry	
12	withir ene. than	Ę.	Elementary/Secondary (0-12)	College (1-4o	r 5+) ""6	Homemake	,		Own Ho	ome	
	Hygie Hygie other ant, II		17. Father's Name (First, Middle, Last)			Tioniemake		er's Name (First, Middle	e, Maiden Suman	ne)	_
an	ould be i Mental I arked o	To Be	John Anthony Kee	gan			Ber	rnice Conr	iff		
Maryland	ages 1 and 2 should be filed within of Health and Mental Hygiene. It if Item 27 is marked other than corother trample or other traumatic event, that Mental traumatic event, that Mental traumatic event, that Mental traumatic event, that Mental traumatic event, that Mental traumatic event, that Mental traumatic event, that Mental traumatic event, that Mental traumatic event, that Mental traumatic events that Mental traum	F .	19a. Informant's Name/Relationship (7	Гуре, Print)	19b. Ma	iling Address (Street	and Numbe	er or Rural Route Num	ber, City or Town,	, State, Zip Code)	-
	and 2 ealth a n 27 is		Joe Meyers/son		160	4 Wadswort	th Wav	/, Baltimor	e. MD.	21 239	
ē,	f Hearling of the		20a. Method of Disposition		20b. Place of Dis		1.0	Date		- City or Town, State	_
9	Pages nent of h int: if Ite iry or o		1 Burial 2 □ Cremation 3 □ 4 □ Donayon 5 □ Other (Specify		θ	Valley Me	U	4/24/2006	Timoniu	m, Maryland	
Baltimore,	2 E E E		21. Signature of Funeral Service Licen	·	DUTULEA	22 Name and Addre	ss of Facili			ral Home, Inc.	
ä	Department Department Important in processing		Stepl Stepl	nen Coste	r	1050 York	Road,	, Towson, M	larvland	21204	
24			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	ofications that caus	ed the death. Do not e	nter the mode of dyir	ng, such as	cardiac or respiratory	arrest,	Approximate Interval Between	
	Physician		Immediate Cause (Final	one cause on each	1//	of ca	v.C.	noma	_	Onset and Death	
	/Medical		disease or condition resulting in death)	aDue to (or a	is a consequence of):	71 00		-		3/06	_
32	Examiner			b							
	P =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		is a consequence of).						
	The law requires that the death certificate be executed tie has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Examiner	triat initiated events	c							
0,	be execute sician and burial-trans		resulting in death) Last	Due to (or a	is a consequence of):						
8760,	the b	dicai		d.							
9	death certific attending p	Mec	IF FEMALE:								
Вох	ath ce ttend or us	Physician/Me	23b. Was decedent pregnant in the past 12 pronths?		2 Fetaf death 3	Ectopic pregnancy	у			ite of delivery onth Day Year	
0.	t the dea by the a tached for	SIC	1 ☐ Yes 2 █ No 9 ☐ Unknown	4∐Pregnant 9∐ Unknown		Other (specify)					
٩.	that the ed by detac		Part II. Other significant conditions c	antributing to death	but not resulting in the	underlying cause an	en in Part I	23e Did	tobacco use cont	tribute to the cause of death?	
JS,	uires tha signed Ild be del	ò	Ture ii. Ottor organioani oorianiono	on mounty to south	but not rooming in the	andonying dadab gre			Yes 2□No	3 Probably 4 Unknow	m
Records,	w requ been should	Completed						-			
%ec	elaw hast e2s	du							s an 24b. opsy ormed2	Were autopsy findings available prior to completion of cause of death?	10
_		S .						1 ☐ Yes	2. No	1 ☐ Yes 2 ☐ No	
Vital	tician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	11-20- 200-	Oth		of Death (Check only		Sons	
of	hys this al dir	2	1 ☐ Yes 2 No 27. Manner of Death	1 🗆 Inpa			101: 4 □ Nu	rsing Home 5 Res	idence 6 Oth	ner (Specify)Residence	2_
		0	1 Natural 5 ☐ Pending	28a. Date of In (Month, D	njury 28b. Time Day Year) fnjury	Wor	rk? Yes 2 □		how injury occur	red	
isic	uttendi death. ctor: A y the fu	Cat	2 Accident investigation 3 Suicide 6 Could not be		njury - At home, farm,				(Street and Numb	ber or Rural Route Number,	
Division	or Attendation after death Director: A	Certification:	4 Homicide determined	building,	etc. (Specify)	street, factory, office		City or To	wn, State)	TOT OF THE ATT TO GET THE THE TOTAL	
_	ours ours neral filled		29a. Certifier 1 € Certifying Ph	vsicien: To the bes	st of my knowledge, de	ath occurred at the tir	me date an	d place, and due to the	cause(s) and ma	anner as stated	
	24 ho	Medical		niner: On the basis	of examination and/or	investigation, in my o	ppinion, dea	th occurred at the time	, date and place,	and due to the cause(s)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Me	29b. Signature and title of certifier			29c. Licens	se number	20.51	29d. Date signe	ed (Month, Day, Year)	
	->-0		V/Sila	w	()	- 0	25	39/	4-1	18-2006	
	7		30 Name and address of person who	ompleted cause of	death (ftem 23a) (T	e, Print)	7.	2. 11	10	alfinde	
8	70		M'KHAN	5.6	01-2	ochK	ave	n /5/v	d 115	alphole 313	3
14 - Q	Sta	ate	31. Date filed (Month Pory, mear) 2	NNS 32 Regis	strar's Signature	partie				- Car	(

DHMH 17 Rev 1/2001

			For State Registrar	State of Marylan		nt of Health and te of Death		ene 006	2.7
>	Physicia /Medic Examin	al	1. Depedent's Name (First, Middle, Las	6.	bsoital Ba	AZE ROD Town, or Location of Dec Itimore	2. Date of Death Month	Day Year 2000	3. Time of Death
	Funeral Director		214 04 7303	7. Age (In yrs. 46	Ast birthday) If Und Months			'ear) 1959 9. Birth	nplace (State or Foreign
	Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD Carro		y, Town or Location New W	indsor			10d. Inside City Limits 1 ☐ Yes 2☐ No
	h with the	Funeral Director	10e. Street and Number 1526 Dennings Roa	ıd	10f. 2	(ip Code 21776	10g	g. Citizen of What Cou USA	intry?
036	urs after deatl al', or items 2 Exeminer mu	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		edent of Hispanic Origin? (ecify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Amer 8lack, White Specify: Wh	
21215-0036	be filed within 72 hours after death with the Maryland thy typene. d other than "netural", or items 23e or 28e-f show event, the Madical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Decedent's Us (Give kind of v life. DO NOT Homemak	vork done during most of w use retired)	orking 16	Domestic	,
and	4 d in 6	To Be C	17. Father's Name (First, Middle, Last) Charles Philli	p German	-		ame <i>(First, Middl</i> e, <i>Ma</i> y Jane Mar		
Σ	id 2 shou Ith and M 27 is mar treumat		19a. Informant's Name/Relationship (7 Mr. Kevin Neal Naz	ype, Print)		ss (Street and Number or F	Rural Route Number, (City or Town, State, Zi	
nore,	Pages 1 and 3 nent of Heelth int: if itam 27 iry or other tr		20a. Method of Disposition 1 Burial 2 XCremation 3	Removal from State	Place of Disposition (Nemetery, crematory of	remation 4/2		oc. Location - City or T	
Baltimore,	permit. Pages 1 and 2 should Depertment of Heelth and Men Important: if Itam 27 is marke any injury or other treumatic. once.		4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen		²² HATG	ATAFONERAL HOSVILLE, MD 2	OME & CHAP	ykesville, EL, PA (Bo	
	-hysician /Medical Examiner	her	23a. Part 1. Enter the disease, or composhock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Put of or as a conseq b. Due to (or as a conseq	h. Do not enter the mu	ode of dying, such as cardi		t,	Approve ate Interval Between Onset and Death
8760, <	The law requires that the death certificate be executed tie has been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conseq	uence of):				
.O. Box 6	that the death certifica ed by the ettending ph detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3 □Ectopic			23d. Date of deliv Month	very Day Year
rds, P.	w requires that s been signed to should be deta	è	Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlying	cause given in Part I.	23e. Did toba 1 ☐ Yes	cco use contribute to	
	The law reate has bee page 2 sho	Completed	Graft Ve	rsus t	tost I	isease	24a. Was an autopsy performe	prior to ce	opsy lindings available ompletion of cause of
Vita	sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ER/Outpatient 3□ I	Othor	eath (Check only one) Home 5 Residen		(A)
Division of Vital	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funerel Director: Atter this certificate ha completely filled in by the funeral director, page	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how		<u>''y</u>)
DIVIS	tel or Atta s after de el Directo ed in by tl	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif		ory, office	28f. Location (Stre City or Town,	et and Number or Rui State)	al Route Number,
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: / completely (illed in by the t	edicai	29a. Certifier Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occurre tion and/or investigation	ed at the time, date and place on, in my opinion, death oc	ce, and due to the cau curred at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
)	To T Fo t	Σ	29b. Signature and title of certifier	A MEDICAL		9c. License number	290 A	d. Date signed (Month)	Day, Year)
	6		30. Name and address of person who			lfe street	Baltimo	ro Mary	and 212.27
	Sta Regist		31. Date filed (Month Par Par) 4	2006 32. Fisqistrar's Signa	atury A	0	West 17110	TK / TAIL	

			1 - For State Registrar	State of Maryland		rtment of H			ene 0 0 6	12712
ı	Physici /Medic		1. Decedent's Name (First, Middle, Last) $\label{eq:G.G.} \boldsymbol{G.}$	JEANNE		OTTENHE	IMER	2. Date of Death	Day Year 17 2006	3. Time of Death
	Examin		4a. Facility Name (If not institution, give s KESWICK NURSING 5. Social Security Number 6. Sex	HOME 7. Age (In yrs. In	ast birthday)	4b. City, Town, or If Under 1 Year Months Days	BALTI If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Birth	N/A Dlace (State or Foreign
	Director		Usual Residence of Decedent		38 Yrs.		Hours Min.	JULY 4,	1917	MD
	sa Marylar 8e-f show	Director	MD BALTI		r, Town or Lo BAL	TIMORE				10d. Inside City Limits 1 ☐ Yes 2 No
	ath with the 23a or 2	ral Dire	ONE SLADE AVENUE			10f. Zip Code	21208		g. Citizen of What Cou	USA
036	urs aftar das al', or Itams Exercicer n	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 🏋 Widowed 4 □ Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	,	Vas Decedent of H f Yes, specify Cuba I□Yes 2\n No	ispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify:	
1215-003	ba filed within 72 hours aftar death with the Maryland tall Hygiene. Id other then "natural", or Itams 23a or 28e-f show other then "natural", or Itams 23a or 28e-f show event, I're Medical Eventies in that the mailied at	Completed	15. Decedent's Educ (Specify only highest grade		(Give life. l	tent's Usual Occup kind of work done of OO NOT use retired PTIONIST	during most of work	ing	SINAI HOSP	,
Maryland 2	2 should be filed withir and Mantal Hygiene. Is marked other then aumatic event, I'e M	To Be Co	17. Father's Name (First, Middle, Last) MICHAEL		SCHER	}	18. Mother's Name	e (First, Middle, Ma		FRIEDLANDER
	12 mg		19a. Informant's Name/Relationship (Type MINNA CULINER /	DAUGHTER	2016	BURDOCK	ROAD - BA	LTIMORE,	City or Town, State, Zip MD 21209	
altimore,	d 0		20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3 □ R 1 □ Donation 5 □ Other (Specify)	emoval from State ARLI	MGTON		MUNO 4/21	/2006	BALTIMOR	E, MD
Bai	parmit. Page Departmant: Important: II any injury o		21. Signate of Funeral Solvice-License	•			STERSTOWN	ROAD -	SON & BROS PIKESVILLE	, MD 21208
	Pnysician /Medical Examiner		23a. Parff. Enfer the disease for complications of heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death e cause on each line. Due to (or as a consequ	uence of):	er the mode of dyin	ig, such as cardiac of imth Hen dych	in agia	r and	Approximate Interval Between Onset and Death 3 Manflux
8760,	ficate be executed physicien and ts the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ						
P.O. Box 6	tha death cartifii the attanding p ched for usa as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregna: 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)	,		23d. Date of deliv Month	ery Day Year
	w raquiras that tha de baan signad by the a should ba datached f	by	Part II. Other significant conditions con	tributing to death but not resu Lewentia	ulting in the u	nderlying cause giv	en in Part I.	23e. Did toba 1 ☐ Yes	cco use contribute to t	he cause of death?
al Records,	i: Tha law ra icata has ba r, paga 2 sh	Completed						24a. Was an autopsy performe 1 ☐ Yes 2 €	prior to co	opsy findings available impletion of cause of
Division of Vital	To the Hospital or Attending Physician: Tha law requires that the death cartif within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending completely filled in by the funaral director, page 2 should be deteched for use a	tlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Mann of Death 1 Valural 5 Pending investigation	ospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injur Wor	er: 4 Unursing Ho	n (Check only one) me 5 ☐ Residen 28d. Describe how	ce 6 ☐ Other (Specia	(y)
Divisi	al or Attends after death al Director:	Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (Stre City or Town,	et and Number or Run State)	al Route Number,
	To the Hospital or within 24 hours afte To the Funaral Dir complataly fillad in	Medical		sician: To the best of my knowner: On the basis of examinat and manner stated.						
)	To the within To the comp	Ž	29b. Signature and title of certifier Mulabelle VI	lac grego	O20 2	29c. Licens			1. Date signed (Month, famil 18, 2	
			M Babelle VI 30. Name and address of person who co TDIABELLE TIX	mpleted cause of death (Item SREGIR, 701	23a) (Type,	Print) OK STRE	E, BAI	TIMORE,	1002121	1
	Sta Registi		31. Date filed (Month, Day, Year) APR 2 4 296	32. registrar's Signal	ture	new				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

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			1. Decedent's Neme (First, M.	iddle, Last	")						2. Date of De	eeth		V	3. Tin	ne of Death
н	Physici		ROSE		POT	THAS	Т				April	22,	20	Year 06	12	:05AM
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	dea G	ner	11. Marital Status		12. Was Decede Armed Force	nt Ever in U	,S. 13. W	as Dece	edent of F	lispanic Origin? (Specify Yes or No rto Rican, etc.)	D-		e - America		n,
036	72 hours after death with the Maryland "natural", or items 23a or 28a-f show idical Examiner must be notified at	by Fu	1★ Never Married 2 Never Marr	1	1 ☐ Yes 2[If Yes, Give Year or Date	∭No				Specify:	110011, 000.7			w Whi		
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ē,	s 1 end 2 of Health e Item 27 is other tra		20a. Method of Disposition			20b. F	Place of Dispos cemetery, crem	ition (Na	me of	201	Date	20c. l	Location -	City or Tow	n, Stat	е
Baltimore,	permit. Pages Depertment of Himportent: if Ite any injury or of once.		1 ☑ Burial 2 ☐ Cremetic 4 ☐ Donation 5 ☐ Other				y Redee				4/26/06	Ra	1 time	re, M	larv	1 and
Ħ	nit. 1	l	21. Signature of Funeral Serv			7 1	22.	Name a	nd Addre	ss of FacilityS t	erling A	sht	on Sc	hwab	Wit	zke
Ö	P P E S		/ /M	Lo	(//						atonsvil			- 1470	2.1	220
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ð	Phys arthis arel d		27. Manner of Death		28e. Date of Ir	njury	28b. Time of		28c. injur Wor		28d. Describe					·
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Division	Atternation of the part of the py the	Certification:	3 ☐ Suicide 6 ☐ Cou	ld not be ermined	28e. Plece of I	Injury - At ho	ome, farm, stre	et, factor	y, office		28f. Location (City or To			er or Rural	Route I	Vumber,
	rs effe	Ce			Donaing,		,,									
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	of the of the course of the co	Me	29b. Signature and title of cert	ifier	1	1		29	c. Licens	e number				(Month, D		
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Patient Known as Khonon Sternin Baltimore, Maryland 21215-0036

			For	Please Amend i	Type or Printed 9 per State of Ma	nt in I fh g arylai					All Copies Mental Hy	s Are /giene	Legible.	12711
			Registrar				Ce	ertifica	ate of	Death		Reg. No	. 000	16.1159
	Physici /Medic	_	1. Decedent's Nam	ne (First, Middle, La	st)			ST	ERNIN		2. Date of D Month, April	Da	y 200	
	Examir	20	Sin	ai Hos	s pital	of	BaHim	e Ba	iltimo		7		. County of De	N/A
	Funeral Director		5. Social Security I 219-23- Usual Residence of	7019	M 2□F	83	last birthda Yrs.	Month	der 1 Year ns Days	If Under 24 H		1923	9. Bi	rth Belanus Foreign country) RUSSIA
	e Maryland la-f ehow	Director	10a. State MD	10b. County N/A			ty, Town or ALTIMO							10d. Inside City Limits 1 Yes 2 No
	eth with th	rai Dire			rs avenue				Zip Code 21215				U.S.A.	
980	d within 72 hours after deeth with the Maryland Jiene. rithen "natural", or Iteme 23a or 28a-f ehow The Madical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Mar 3 ☐ Widowed	ried 2 Marned 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give X Year or Dates:		J.S. 13		cedent of h pecify Cub 2 No	dispanic Origin? an, Mexican, Pue Specify:	(Specify Yes or N erto Rican, etc.)	0-	14. Race - Am Black, Wh Specify: W	
15-0	n 72 h	Completed		15. Decedent's E cify only highest gra	ade completed)		(Giv	e kind of	sual Occup work done Fuse retire	during most of w	orking	16b. K	ind of Business	s/Industry
212	d within glene. or then	mo:	Elementary/Sec	ondary (0-12)	College (1-4or 5 5+	5+)	NAVAL		MANDE	•		RUS	SSIAN M	ILITARY
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Aan)	2 should and Men ie marke raumatic			lame/Relationship (1				Rural Route Numi	-		
	1 and Health tem 27 other ti		ROSA ZU 20a. Method of Dis		JGHTER		Place of Disp	position (/	Vame of		JRI - KE Date		Cation - City o	MD 21136
Baltimore,	Pages nent of I unt: If Its ury or o			☐ Cremation 3 ☐ 5 ☐ Other (Special	Removal from State (y)	ВА	cemetery, ci LTIMOR	ematory o	BREW	CONG 4/2	21/2006		STERSTO	
Balt	permit. Page Department of Important: If eny injury or		21. Signature of F	uneral Service Lice	nsde						SOL LEVI N ROAD -			., INC. , MD 21208
,	Physician /Medical		23a. Part / Enter shock, or her Immediate Cause disease or conditi resulting in death)	(Final on	one cause on each li						Kem r			Approximate Interval Between Onset and Death
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68760,			resulting in death)	Last	Due to (or as	a consec	quence of):							
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	98 09 09	۵	Part II. Other signi	ificant conditions	contributing to death b	ut not res	sulting in the	underlyin	g cause giv	ren in Part I.		tobacco (_	o the cause of death?
Division of Vital Records,	The ate h page	Completed									24a. Was auto perf 1 Yes		prior to death?	utopsy findings available completion of cause of
/ita	iicien: Th certificate rector, pag	Be (25. Was case refe	rre o medical						26. Place of D	eath (Check only	one)		
on of \	Phys this rat di	lon: To	1 ☐ Yes 2 ☑ 27. Manner of Dea 1 ☐ Matural	th 5 ☐ Pending	Hospital: 1 V Inpatie 28a. Date of Inju (Month, Da	iry	ER/Outpati 28b. Time Injury	of	28c. Inju	4 🗀 Nursing	Home 5 Res			ecify)
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	To the Hospitel within 24 hours a To the Funeral completely filled	ledical C	29a. Certifier (Check only one)	1 ☐ Certifying Pt 2 ☐ Medical Exa	nysician: To the best miner: On the basis of and manner sta	f examina	owledge, dea ation and/or	ath occurr investigati	ed at the tilion, in my d	me, date and pla opinion, death oc	ce, and due to the curred at the time	cause(s)) and manner a d place, and du	s stated. e to the cause(s)
	To th To th compl	Me	29b. Signature and	title of certifier	11	`		- 2	29c. Licens				te signed (Mon	
	6		×	1	///		10		KE	S-00	0	AP	ril 18	2006
	0		30. Name and add	Mole (completed cause of d	leath (Ite	m 23a) (Type	Pita	104	Balti	more.			
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		Please	Type or Prin							_		_	bie.		
		1 - For State Registrar		State of Maryland / Department of Health and Mental F Certificate of Death								00	6	127	15
Physici	an	1. Decedent's Name (First, Middle, Las	· · · · · · · · · · · · · · · · · · ·				CLIDDIN 2. Da					y ,	Year	3. Time o	Death
/Medic	al	EMMA 4a. Facility Name (If not institution, give street and number)			SURDIN 4b. City, Town, or Location of Death					april	40	County	OCC Death		13PM
Examin	er	Sinai Hosp	Halof		timore		r 1 Year	A L + i	ma			· oounty		N/A	
Funeral Director		5. Social Security Number 6.'S 220-05-7206 1 Usual Residence of Decedent	ex 7. Aga	85 85	last birthday) Yrs.	Months	Days	Hours	Min.	AUG. 18		20	9. Birti	iplace (State ountry)	
hours after death with the Maryland hours after death with the Maryland lurel; or Itema 23a or 28a-f show at Exertirer must be notified at	tor	10a. State 10b. County N/	, Town or Location BALTIMORE						10d. Inside City Limits 1 Yes 2 □ No						
	Director	10e. Streef and Number 7211 PARK HEIGHTS AVENUE #401			10f. Zip Code 21208						itizen of What Country?				
s after death or itema 23	by Funerai	11. Marital Status 1 Never Married 2 Married	1. Marital Status 1. Marital Status 1. Never Married 2 Married 1. Was Decedent Ever in U. Armed Forces? 1. Yes 2 M No # Yes Give									Blac	4. Race - American Indian, Black, White, etc. Specify: WHITE		
		3 🕅 Widowed 4 □ Divorced 15. Decedent's Ec (Specify only highest gra	(Give	a. Decedent's Usual Occupation (Give kind of work done during most of working					16b. Kind of Business/Industry						
filed within 72 ho Hygiene. Wher then "netu	Completed	Elementary/Secondary (0-12) Coffege (1-4or 5+) 17. Father's Name (First, Middle, Last)			HOUSEWIFE					OWN HOME					
should be find Mental H	To Be	SAMUEL SAMUEL		OLDBER	G				(FIFSI, MIGGIE	, машел	Suman	10/	KRAUS	SE	
and 2 sho ealth and m 27 ie m		19a. Informant's Name/Relationship (RON SURDIN / SO	** '							OWINGS					
permit. Pages 1 and 2 should be filed within Department of Health and Montal Hygiene. Important: if item 27 is marked other than any injury or other treumatic event, ITAMS once.		20a. Method of Disposition 1 N Burial 2 Cremation 3 Removal from State 4 Dayoftion 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) ARLINGTON CHIZUK AMUNO 4/21/2006 BALTIMORE,													
permit. Departm Importa any inju		21. Signature of Funeral Service Life	Truo e								NSON & BROS., INC. PIKESVILLE. MD 21208				
Physician /Medical Examiner		23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cache on each fine. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Approximate Interval Between Onset and Death Due to (or as a consequence of):													
icate be executed physician and s the burial-transit	cal Examiner	b. Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):													
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w requires that been signed by should be deta	þ	Part fl. Other significant conditions of	fting in the underlying cause given in Part I. 23e						Did fobacco use contribute to the cause of d				death? Unknown		
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ician: T certificat rector, p	Be (25. Was case referred to medical examiner?	26. Place of Death (Check only one)												
Phys this al dii	٦	1 Yes 2500								Home 5 ☐ Residence 6 ☐ Other (Sp				ify)	
g e	ation	1 Accident 5 Pending investigation								28d. Describe how injury occurred					
To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, efc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)					
the Hospital or hin 24 hours afte the Funeral Dir npletely filled in	Medical	29a. Certifier (Check only one) Certifying Ph 2 Medical Exam	ysician: To the best on ninar: On the basis of and manner sta	examina	wledge, death tion and/or inv	occurred	at the tim	e, date and inion, death	place, a	and due to the ed at the time.	cause(s) date and	and ma d place, a	inner as and due	stated. to the cause(s	5)
To th within To th	Me	29b. Signature and title of certifier	29c. License number					a)		29d. Da	Date signed (Month, Day, Year)				
,		30. Name and address of person who	1 23a) (Type, I	23a) (Type, Print) 227 St. Paul Place Ball					Jeshi (col con						
Sta	te	MARVIN J. FE 31. Date filed (Month, Day, Year)	COWAW 32 Registra		227 ture	ST.	rel	Moc	c 13	a (tim	210/	6,6	60	2120	2
Registr		APU 2 = 20H	16 All sun		ture	W. J.									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 19 Day 2006 Year **Physician** Lewis Thomas Thorpe 9:45 AM /Medical 4a. Facility Name (If not institution, give street and number)
Southern Maryland Hospital 4c. County of Death 4b City Town or Location of Death Examiner Prince George's Clinton If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, OCT 5, 9. Birthplace (State or Foreign North Carolina 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min MM 2□F 82 Yrs. 241 26 0533 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 28a-1 show r than "natural", or items 23a or 28a-1 show the Madical Examinar must be notified at 1 Yes 2 No Clinton Maryland Prince George's Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5737 East Boniwood Turn 20735 United States death 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Center Completed 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Washington Hospital 12 Housekeeping Pages 1 and 2 should be filed vitnent of Health and Mental Hygie tent: If item 27 is marked other toury or other traumatic event, In other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Martha Holden Jeffreys Thorpe Sylvester permit. Pages 1 and 2 shoul Department of Health and Me Important: If Item 27 is markeny injury or other traumationce. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5737 East Boniwood Turn, Clinton, MD 20735 Althea T. Roberts (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Buriai 22. Cremation 3 ☐ Removal from State Lee Crematory April 28, 2006 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old 21. Signature of Funeral Service Licenses 1000 Alexandria Ferry Road, Clinton, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or peach line. Immediate Cause (Final Myocarchy **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dua to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached t 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? advance (arcinoma 1 Yes 2 No 3 Probably 4 □Unknown been si 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No certificate 1 Yes 25. Was case referred to medical examiner?

1 Pres 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manny of Death : After this funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Injury 5 Pending М 1 ☐ Yes 2 ☐ No I Director: A investigation death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours after To the Funeral Dire 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title D0055120 In who completed cause of death (Item 23a) (Type, Print)

1328 Junthen Quumu SE Swite STO Washington DC Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State C	of Marylan		artment of He			ene g. No. 0 0 6	12717
	Physicia	an	Decedent's Name (First, Middle, Last) MARGA	ARET F	ΤΛ	TE		2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin	al	4a. Fecility Name (If not institution, give street and nu		• 17	4b. City, Town, or I		April 2	0 2006 4c. County of Death	12:30 p [™]
			Greater Baltimore Medic			Towson	W.U		Baltimore	
	Funeral Director		5. Social Security Number 219-18-4379 6. Sex 1□ M XX F	7. Age (In yrs. 85	last birthday, Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 12-09-1	9. Birth Cou	place (State or Foreign htry) ARYLAND
			Usual Residence of Decedent 10a. State 10b. County	10c Cit	y, Town or L	ocation				10d. Inside City Limits
	the Marylan 28a-f show	o	MD. BALTIMORE	100.01	y, TOWITOI L	TOWSO	ON		\vee	1 ☐ Yes 2/CXNo
1	death with the Maryla me 23a or 28a-f sho	al Director	10e. Street and Number 800 SOUTHERLY ROAD			10f. Zip Code	21286	10	U. S.	
ARE 336	ırs after death v il', or Iteme 23a xar∴lı er munt	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Was Dec Armed F 1 Yes 1 Yes, G 1 Year or Vear or I	cedent Ever in U. orces? 2 No ive Dates:	S. 13.	Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 為XNo	panic Origin? (Spec , Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Ameri Black, White Specify:	
1215-0036	within 72 hours after death with the Maryland ene. than "natural", or Iteme 23s or 28s-f show tha Medical Exatit or front be notified at	Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College 5 PLUS) (1-4or 5+)	(Give	dent's Usual Occupat kind of work done du DO NOT use retired) TEACHER	iring most of workin	g 1	BALTIMORE DEPARTMENT	COUNTY OF EDUCATIO
/ W	2 should be filed and Mental Hygi Is marked other aumatic event, I	To Be C	17. Father's Name (First, Middle, Last) HERBERT	FALLI	N		18. Mother's Name MARGARE		Maiden Sumame) TRUDE KIRK	
Mary.	s 1 and 2 should I f Health and Men frem 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print) JAMES F. TATE (SON)		2121	JAMIESON /	AVE.#2009	, ALEXAND	City or Town, State, Zi ORIA, VIRGIN	IA, 22314
ATT	Pages 1 and of He ant: if Item		20a. Method of Disposition 1 ☐ Burial XX ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	0	emetery, cre	osition (Name of matory or other place SERVICE CO)		OWSON, MARY	LAND,21204
Balti	permit. Pages Department of Important: if its any injury or o		21. Signature of Funeral Service Licensee	G. RUTH)		2. Name and Address UCK TOWSON		HOME, IN	1050 YO IC. TOWSON,	RK ROAD MD.21204
8760,	The law requires that the death certificate be executed Exam The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the death certificate be executed to the death certificate be executed to the death certificate be executed to the death certificate be executed to the death certificate be executed to the death certificate be executed to the death certificate between the death certificates and the death certificates the deat	ilcal Examiner	Sequentially list conditions	each line. Consulting Or as a consequence Cor as a consequence Or as	dence of):	011	untulnic)			Approximate interval Between Onset and Death
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	uires that I signed by id be deta	Š	Part II. Other significant conditions contributing to	death but not res	ulting in the	underlying cause give	n in Part I.	1	oacco use contribute lo	
Division of Vital Records,	The law require ate hes been si page 2 should t	Completed						24a. Was ar autops perform 1 Yes 2	24b. Were aut prior to c death? 1 \(\sum Yes	opsy findings available ompletion of cause of
Vita	tician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	/		ont 3 DOA Othe	26. Place of Death			
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ivislo	or Attenditer describing the formula of the formula	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place	ce of Injury - At h ding, etc. (Specia	ome, farm, s	M 1 T	'es 2 □No 2	8f. Location (St. City or Town	reet and Number or Ru , State)	ral Route Number,
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	edical Cer	29a. Certifier 1 Sertifying Physician: Totl (Check only 2d Medical Examiner: On the	basis of examina						
	To the within 2 To the complet	Med	29b. Signature and title of certifier	nner stated.		29c. License	number (,) 4.11	29	9d. Date sign∍d (Month	, Day, Year)
	109		30. Name , d addr , s 1 persen who/completed ca	use of death (Ite	7 23a) (Tyloe	Srint) J.	62451 Beltu	n ;	MD 21/1	74
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. APR 2. 4. 2006	Registrar's Sign	ature	aste)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Month Day Genevieve M. Vitek 19, Apr. 2006 0529 /Medical 4a. Facility Name (ff not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 290 Forest Lane Arnold Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Feb. 2, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕱 F 68 213-82-1602 Yrs Director 1938 Paris, France Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a, State 10b. Count 10d. Inside City Limits 28a-1 show the Medical Examiner must be notified at MD Anne Arundel Director Arnold 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 290 Forest Lane 21012 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No ģ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Asst. Cafeteria Manager A.A. County Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental ie marked Unavailable 2 Unavailable 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heelth i Joseph W. Vitek/Husband 290 Forest Lane, Arnold, MD 21012 Important: If Item any Injury or othe ance. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Apr. 2006 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Baltimore, MD Metro Crematory 4 □ Donation 5 □ Other (Specify) Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 21. Signature of Fugeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cholangio Courcinon A mes /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Completed by Physician/Medical as use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 □Ectopic pregnancy Po Month 4☐Pregnant at time of death signed by the at id be detached for 5 Other (specify) o 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Nhknown been 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? certificete 1 ☐ Yes 2 No of Vital director. 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Injury at 28d. Describe how injury occurred 1 ☐ Yes 2 No this within 24 hours after death.

To the Funaral Director: After thi
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c, Injury at Work? Medical Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide the Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier IA 0101229159 wbp completed cause of death (Item 23a) (Type, Print) 10an

DHMH 17 Rev 1/200

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

2006

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	ns 23	Funeral	1427 PERRYWOO	12. Was Decedent 8	Ever in U.S. 13	. Was Decedent	of Hispanic Origin? (S	Specify Yes or No	o- 14. F	S.A. Race - Amer				
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ore,	of Heal		20a. Method of Disposition		20b. Place of Disp		of !	Date		on - City or T	Town, Slate			
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Baltimore,	permit. Pages Depirtment of h Important: If tte any njury or of 2005.		21. Signature of Family Service 9	weels	′	WILLIAM	ddress of Facility C BROWN CO				RFORD, P.A.			
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused	the death. Do not e						Approximate Interval Between			
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	/Medical		resulting in death)		a consequence of):									
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P.O. Box	Physician: The law requires that the death centit this certificate hes been signed by the ettending rat director, page 2 should be detached for use a	Physician/M	23b. was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		□Ectopic pregn	ancy		23d.	Date of delive	very Day Year			
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	that the	Ph	Part II. Other significant conditions co	entributing to death be	ut not resulting in the	underlying caus	e given in Part I.	23e. Did	tobacco use c	ontribute to	the cause of death?			
Division of Vital Records,	signe d be	d by		•	•	, ,	•		Yes 2 No		obably 4 Unknown			
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<u>></u>	nysici nis cer direc	To B	examiner? 1 ☐ Yes 2 No	Hospital:	nt 2 ER/Outpati	ent 3 DOA	Other: 4 Nursing I	Home 5 ☐ Res	idence 6 🗆	Other (Spec	cify)			
0	ng Pt		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injui (Month, Day	y 28b. Time (Year) Injury	of 28c.	Injury at Work?	28d. Describe	how injury oc	curred				
sio	Attanding it death.	cati	2 Accident investigation 3 Suicide 6 Could not be	-		М	1 ☐ Yes 2 ☐ No	ORG L parties	(Canada and M)	mba - D	-18			
Σ	or At offer Direction by	Certification:	4 Homicide determined	building, etc	ury - At home, farm, s c. (Specify)	street, lactory, of	tice		wn, State)	imber or Hui	ral Route Number,			
	To the Hospital or Attending Physician: The law within 24 hours elter death. To the Funsral Director: After this certificate hes completely filled in by the funeral director, page 2	a C	29a. Certifier Certifying Phy	sician: To the best	of my knowledge, de	ath occurred at t	ne time, date and plac	e, and due to the	cause(s) and	l manner as	stated.			
	ha Ho in 24 i ha Fu pieteli	edical	(Check only 2 Medical Exam	iner: On the basis of and manner sta		investigation, in	my opinion, death occ	urred at the time,	, date and plac	e, and due	to the cause(s)			
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	9		30. Name and address of person who of Indrani Mukher	completed cause of d	eath (Item 23a) (Type ohns Hocki	ns Hoso	ital, 600 N	orth Wol	Fe Stree	et, m	itimore			
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1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** DOROTHY V. WALDMAN 12:53 PM APRIL 21 2006 /Medical 4a. Facility Name (If not institution, give street and number)
ST: AGNES HEALTH CARE 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE BALTIMORE CITY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State (Month, Day, Year) | MARCH 13, 1931 | MARYLAND 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1 M 2 X F 217-26-2656 75 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County an "natural", or items 23a or 28a-f ehow Medical Examiner must be notified at 1X Yes 2 No BALTIMORE CITY BALTIMORE MARYLAND Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Miscipal Examinar mountaine. 21230 UNITED STATES 3023 JANICE AVE. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∏Yes ≥ ZMNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ WHITE 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WILLIAM JOSEPH WEIMAN GERTRUDE CALDWELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 1218, SEVERNA PARK, MD 21146 FLORENCE JORDAN / DAUGHTER 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State METRO CREMATORY, INC. CATONSVILLE, MARYLAND 4 □ Donation 5 □ Other (Specify) 21. Sign ture of Funeral Service KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061 icense Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Immediate Cause (Final disease or condition resulting in death) Physician SEPSIS 2 DAYS /Medical Due to (or as a consequence of): Examiner ACUTE RENAL FAIWRE 2 DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): 68760 Physician/Medical Box (IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4 Pregnant at time of death has been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an 1 Yes 2 No certificate Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) After thi 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident filled in by the Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide ŏ To the Hospital within 24 hours a To the Funeral completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier APRIL, 21, 2006 Suvaechala P19923 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST. AGNES HOSPITAL, BALTIMORE, MD SUUARCHALA KOMPELLA, MD 31. Date filed (Month, Pay Year) 32. egistrar's Signature State 4 2006

Registrar

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		1. Decedent's Name (First, Middl								2. Date of De	_	×	_Year _	3. Time of Death
Physicia /Medic		Dorothy Eli	zabeth We	111	ng					Apri 1		Ď,	2006	7PM
Examin		4a. Fecility Name (If not institution Lorian Nursing		ımber)		4b. City, 1 Balti		Location 6	of Death		4c	. Count	y of Death	
Funeral Director		5. Social Security Number 212-34-4163	6. Sex		e (In yrs. last birthday 90 Yrs.	Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Di December	rth ay, Year) 26,1	915	9. Birthp Cour Ma	lace (State or Forei itry) iryland
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene Hygiene Hygiene 1 strain and Sa or 28a-1 show important; if item 721s marked other than "natural; or Items 23a or 28a-1 show any injury or other traumatic event, if a Machinal Examination confilled at once.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland N/A 10e. Street and Number 4816 Wright Ave 11. Marital Status 1 Never Married 2 Mary Widowed 4 Divorced (Specify only higher Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, John Milton Fic 19a. Informant's Name/Relations Robert A Wellin 20a. Method of Disposition XX Buriat 2 Cremation	12. Was Dec Armed F 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	orces? 2/CM ive Dates:) (1-4or 5	Son 7347 20b. Place of Disp. cemetery, cre.	was Decedif Yes, spec 1 □ Yes 2 edent's Usua b kind of won Homen Homen Yorkt constion (Name	21. ant of Hity Cuba (X) No Occupation of Architecture of Architecture (Street a COWN) e of her place	Specify: ation furing most 18. Mothing E and Numb P Dri (a)	er's Nam Edith	e (First, Middle 1 Stree ral Route Numb 1 OWSON I Date	16b. K	14. Ra Bla Special Spe	What Cour JSA ce - Americ ck, White, fy: Wh Business/Inc Own H me) J 2120 - City or To	can Indian, etc. In the dustry I ome Code) 14
permit. Pag Department Important: any injury o		21. Signature of Funeral Service 21. Part 1. Enter the disease, shock, or heart failure. List	Specify) Licensee	en	akes	22. Name and	d Addres	s of Facili	Mit York	Road Ba	edefe Itimo	ld F	uneral	Maryland Home Inc. kd 21212 Approximate Interval Between Onset and Death
Physician Percenticate be executed /Medical Examiner and attending physicien and for use as the burial-transit	cai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, 1 a.y. reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. One to	(or as	a consequence of): a consequence of):	n,	ene.	7 6 9						12 4 6-
. 5 . 5	hysician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1							ate of delive	ory Day Year				
uires that the de signed by the Id be detached i	ру Р	Part II. Other significant conditi	ions contributing to	death b	ut not resulting in the	underlying ca	iuse give	en in Part	l.			use cor		ne cause of death? ably 4 □Unknow
ian: The law requires that the trifficate has been signed by the ctor. page 2 should be detached.	Completed									24a. Was auto perf 1 \(\text{Yes}		i	Were auto prior to con death? 1 Yes	psy findings availab npletion of cause of 2□ No
ian: rtific stor.	3e (25. Was case referred to medica	al L				-	26. Plac	e of Dea	th (Check only	one)			

Division of Vital Records, P.O. within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. To the Hospital or Attending Physician: Be Certification:

29a. Certifier 29b. Signature and title of certifier

5 Pending

6 Could not be determined

examiner?

27. Manner of Death

1 Natural

2 Accident

3 Suicide
4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28c. Injury at Work?

1 Yes 2 No

3□ DQA

29c. License number 043386 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

21217 1714 Ecter Place Bultimore NO

State Registrar

31. Date filed (Month, Day, Year) APR 2 4 2006

Itoward 32 Registrar's Signature

1 Inpatient

28a. Date of Injury (Month, Day Year)

CM

2 ER/Outpatient

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hydiging) 0. (

Physician // Medical // Medical // Medical // Medical Examiner out the postilise of the pos	21 2-50-2923 Usual Residence of Decedent 10a. State	give street and number) Hopkins Ho 6. Sex 1 M 2 F 7. Age (In	spirtal yrs. last birthday) 55 Yrs. City, Town or L Timon	Balt If Under 1 Year Months Days	or Location of Deal	Cirty 8. Date of Bir	21 : 4c. County	3	3. Time of	_
Funeral Director	The Johns 5. Social Security Number 212–50–2923 Usual Residence of Decedent 10a. State 10b. County MD Bal 10e. Street and Number 11.3 Longdale	Hopkins Ho 6. Sex 1 M M 2 F 7. Age (In 100	yrs. last birthday) 55 Yrs.	Balt If Under 1 Year Months Days	If Under 24 Hrs	City	⊓√a	3		
Diréctor	Usual Residence of Decedent 10a. State MD 10b. County MD 10c. Street and Number 113 Longdale	1X)M 2□F 10a	55 Yrs.	Months Days		8. Date of Bir Month Da	th У. ^У ЯНБП	9. Birtho		
2	10a. State MD Ball 10e. Street and Number 113 Longdale 11. Marital Status	timore	-	ocation			, 1750	Mai	lace (State or try)land	Foreign
natural, or items 23a or 28e- ikal Examiner must be notificated by Funeral Direct	113 Longdale 11. Marital Status							1	0d. Inside Cit	
natural, or items 23 rai Examinat mus	11. Marital Status				93		10g. Citizen of V	Vhat Cour	itry?	
ratur	3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 TYes 2 No I If Yes, Give Year or Dates:	in U.S. 13.	Was Decedent of I If Yes, specify Cub 1☐ Yes 2☐XNo		Specify Yes or No to Rican, etc.)	- 14. Race Blace Specify	k, White,	an Indian, etc. nite	
	15. Decedent' (Specify only highest	grade completed)	16a. Dece (Give	dent's Usual Occu kind of work done DO NOT use retire	pation during most of wo	orking	16b. Kind of Bu	siness/Ind	dustry	
ygiene. ner than "natura t, Ine Workel	Elementary/Secondary (0-12)	College (1-4or 5+)	(prietor			Bio-Te	ch		
Mental Hyginarked other atic event, I	17. Father's Name (First, Middle, L Clinton	^{ast)} Barry Wils	son		18. Mother's Na Leta	me (First, Middle, Mae		ه) ddlet	on.	
f Health and Men f Health and Men item 27 is marke other treumatic	19a. Informant's Name/Relationship			ing Address (Street Longdale				_	Code)	
3,2 = 5	20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp	3 □Removal from State	ob. Place of Dispo cemetery, cre Dulaney	osition (Name of matory or other pla Valley Me	em'l 4/2	Date 25/06	20c. Location -			
Department Important: eny injury once.	21. Signature of Funeral Service L	william G		2. Name and Addre				al Ho	me, Ir	IC.
hysician /Medical Examiner	23a. Pan1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	complications that caused the only one cause on each line. PREUM Due to (or as a cor	nonia		ng, such as cardia				Approximate Interval Betwonset and Dine we	veen Death
initiate be executed as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	nsequence of):							
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6 8 6 8	Part II. Other significant condition	ns contributing to death but no	t resulting in the u	underlying cause gr	ven in Part I.	23e. Did t	obacco use conti res 2 PNo		e cause of de ably 4 □U	
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00	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Minpatient	2 ER/Outpatie	nt 3 DOA Ott	hon	ath Check only of Home 5 Resid		or /Snecifi	d)	
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s after death. al Director: After the din by the funeral death. Certification:	3 Suicide 6 Could n 4 Homicide determi	ot be		reet, factory, office		28f. Location (S City or Tox	Street and Number vn, State)	er or Rura	l Route Numb) <i>01</i> ,
Funer Funer ely fill ical	29a. Certifier 1 Certifying (Check only one)	g Physicien: To the best of my exeminer: On the basis of exa and manner stated.	/ knowledge, deat mination and/or in	th occurred at the ti rvestigation, in my	me, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) and ma date and place, a	nner as st and due to	ated. the cause(s)	
within 2 To the complete	29b. Signature and title of certifier	Annada	Vel III-	29c. Licen	se number	1	29d. Date signed			
it	30. Name and address of person v			, Print)			April:	Bal	timov	e,
	31. Date filed (Month, Day, Year)	32. Ragistrar's S	Or leavis Bignature	Street	Johns Ho	pkins Cl	28-186	Mar	yland	2123

06-02695 Jarell Adams

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		cate of Death		Reg.	No. 0000	10700		
Physicia Medical Exami		1. Decedent's Name (First, Middle Jare.	Adams			April 21, 200	ay Year 06	3. Time of Death/ / 0350 hrs		
		4a. Facility Name (if not institution Johns Hopkins Hospit		4b. City, Town Baltimore	a, or Location of Deatl e	n	4c. County of Death			
Funeral Director		5. Social Security Number 220-08-4/22 Usual Residence of Decedent	6. Sex 7. Age (In yrs. last bi		Year If Under 24Hr Days Hours Mir	,	Foreign	ntry) Md,		
Baltimore, MD 21215-0036 permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Freath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	10a. State 10b. County 10c. Street and Number 11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Div 15. Decedent's Education (Specentary/Secondary (0-12) 17. Father's Name (First, Middle, Secondary (0-12) 19a. Informant's Name/Relations Marie Secondary (0-12) 20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other Secondary (1-12) 21. gnature of Funeral Service	College (1-4 or 5+) Last) Adams Adams 20b. Place cremate cremate cremate consider the constant of the cons	13. Was Decedent of If Yes, specify Control of It Yes, specify Control of I	F Hispanic Origin? (Suban, Mexican, Puerto No specify: upation (Give kind of life. DO NOT use reference and Number of cemetery, Hers of Fallity	work done tired) Work done tired) Work done tired) Work done tired) Work done tired) Work done tired) Work done tired) Work done tired) Work done tired) Work done tired) Work done tired)	14. Race - Americ White, etc. Specify: Black Speci	an Indian, Black, ACK dustry ACMS Zip Code) Md. 2/205 own, State IK, Md.		
Physician /Medical Examiner		23 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List any one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):								
ed nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): c. Due to (or as a consequence of):							
760, icate be executed physician and the burial - transit	/Medical	UNPENDED	a. AMENDED							
Box 68' e death certifi	Physician		23c. If yes, outcome of pregnance 1 Live birth 4 Pregnant at time of death 9 Unknown contributing to death but not resulti	Fetal death Other (Specify)	3 Ectopic pregn		23d. Date of delivery Month Date cco use contribute to the			
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Records, The law requir icate has been s	Completed					24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of		
Vital Rec ysician: The l his certificate	Be	25. Was case referred to medical examiner?	Hospital:		Other Nursi		-:			
Division of Vital Records, P.O. tal or stending Physician: The law requires that the safter death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Certification: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pence	28a. Date of Injury FOUND: FOUND: Apr 24 2006	. Time of Injury 28c.	Injury at Work? Yes 2 No	ng Home 5 Re 28d. Describe hov Subject shot	sidence 6 Other:			
Division Rospital or Attent 24 hours after death Funeral Director:	rtifica	3 Suicide 6 Coul	d not be rmined (Specify) Local Street		ce building, etc.	or Town State	eet and Number or Run e) East Oliver Stree			
D To the Hospital within 24 hours 4 To the Funeral	Medical Ce	29a. Certifier Certifying Pt	nysician: To the best of my knowledge, diminer:On the basis of examination and/or and manner stated.			d due to the cause(s	s) and manner as starte	ed.		
To with	Me	29b. Signature and title of certifie			cense number		9d. Date signed (Mon. April 21, 2006	th, Day, Year)		
			who completed cause of death (Item 23a) sistant Medical Examiner 111	Penn Street, Bal	timore, MD 2120)1				
St Regist	ate trar	31. Date filed (Month, Day, Year)	5 2006 32. Registrar's Signature	Search						
	-									

			For State Registrar	State of Mar		rtment of H			ene 006	12724
	Physici /Medic		1. Decedent's Name (First, Middle, Last) JAMES	AND	REWS			2. Date of Death Month	Day Year	3. Time of Death
10%	Examir		4a. Facility Name (If not institution, give si	reet and number)	CTON	4b. City, Town, or	Location of Death USON If Under 24 Hrs.		4c. County of Death BALTI	MORE
12/4	Funeral Director		5. Social Security Number 6. Sex 944-20-2811 Usual Residence of Decedent	M 2□ F 7. Age (/	n yrs. last birthday) 2 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month: Day, Y	99. Birthp Coun 1923 No. L	lace (State or Foreign try) Ph CARCLINA
0.00.	e Maryland	ctor	10a. State 10b. County MD BALTIMO		Oc. City, Town or Lo				1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
4	th with the 23a or 28e	Funeral Director	10e. Street and Number 3 DALECREST		±303	10f. Zip Code	93	10g.	Citizen of What Coun	try?
36	77 hours after death with the Marylar "natural", or Items 23s or 28e-f ehow solical Examinar must be notilised at	by Funer	11. Marital Status 1 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Eve Armed Forces? 1 ☐ Tes 2 ☐ No ff Yes, Give Year or Dates:		Vas Decedent of His I Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto Specify:	ecfy Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
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and 21	2 should be filed within and Mental Hygiene. Is marked other than sumatic event, the M	To Be Co	17. Father's Name (First, Middle, Last) Samuel A.	ANDREU		4BORER	18. Mother's Name	(First, Middle, Mai	FENCIN iden Sumame) NDRE415	
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JCW Baltimore	it. Page intment o intant: if njury or		20a. Method of Disposition 1 Burial 2 Commation 3 Re 4 Donation 5 Other (Specify) 21. Signature of Fuper Il Service Licens	4	CHIMINE C.	sition (Name of natory or other place)	$c \mid \alpha 0$	26 F	EREST HILL 1800 HAR	11, mD
Ba Ba	perm Depe Impo any i		23a. Part1. Inter the disease, or complic shock, or heart failure. List only one	ations that sed the	E	IANS FUR	VERAL CH	APEC 1	PARKVITTE,	Approximate Interval Between
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7.0D.	es that the death certifice igned by the ettending ph be detached for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	c. If yes, outcome of a 1 Live birth 2 [4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ny Day Year
Δ.	w requires that the death been signed by the etter should be detached for u	ě	Part II. Other significant conditions cont	nbuting to death but r	not resulting in the ur	nderlying cause give	n in Part I.		co use contribute to th	
Division of Vital Records,	The law ste hes b page 2 sl	Completed						24a. Was an autopsy performed 1 Yes 2	d? death?	psy findings available inpletion of cause of
f Vita	Physician: Th r this certificete ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	espital:	2 ER/Outpatien	t 3 DOA Othe	26. Place of Death		e 6 ∏Other (Specify	()
ision o	e fe	Certification;	27. Manner of Death 1 Naturat 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of fnjury (Month, Day Y			'es 2 □No	28d. Describe how		I Pauta Numbar
Div	To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu		4 Homicide determined	building, etc. (City or Town, S		
	the Hosp nin 24 hou the Fune	Medical	(Check only 2 Medical Examination one)	cian: To the best of n	amination and/or inv	restigation, in my op	inion, death occurre	ed at the time, date	se(s) and manner as st and place, and due to	the cause(s)
	To with	2	29b. Signature and title of certifier	2		29c. License	12749	290.	Date signed (Month, I	
_	6+1		30. Name and address of person who con	4 7503	081er 3		whe so	9 Jon	rson m	2 212016
	Sta Registi	-	31. Date filed (Month, Day, Year) APR 2 5 201	32 Registrar's	Signature			1		Ì

	State of Maryland / Department of Health and Mental H	
Division	1. Decedent's Name (First, Middle, Last) 2. Date of Month	Death 3. Time of Death Day Year
Physician /Medical	lovce A. Adams April	1 22 2006 7:45 A M
Examiner	4. English Name (Manufaction of Dooth	4c. County of Death
	Keswick Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of If Under	n/a
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. March	9. Birthplace (State or Foreign Country) Hawaii
	Usual Residence of Decedent	23 1333 114441
rylane how	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Be-f s	MD Baltimore Baltimore	1 ☐ Yes 2 ☐ No
vith the Mar or 288-f st to rediffed	106. Street and Number 227 Gaywood Rd. 21212	10g. Citizen of What Country?
is 23e	227 Gaywood Rd. 21212 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or	I
of the state of th	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married	Black, White, etc.
036 urs at el', or by I	3 Nidowed 4 Divorced If Yes, Give 1 Yes 2 X No Specify: Year or Dates:	Specify: white
21215-00 ed within 72 hou ygjenen "neture ner then "neture it, the Medical Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working	16b. Kind of Business/Industry
21.	Elementary/Secondary (0-12) College (1-4or 5+)	
Col	Tr. Father's Name (First, Middle, Last) 2 Nurse 18. Mother's Name (First, Middle, Last)	Health Care
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If time 27 Is marked other then "neturel; or items 23e or 28e-f show any injury or other treumatic event, the Medical Exercita at must be notified ut once. To Be Completed by Funeral Director		
, Mar and 2 sho balth and m 27 Is m	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Num 19c. Macling Address (Street and Number or Rural Route Num 603 Georgetown Rd., Mechan	
ore, sela	20a. Method of Disposition 1	20c. Location - City or Town, State
imor Pages nent of i	1 A Donation 5 Other (Specify) Dulaney Valley Memorial Gardens	
Balt permit. Departr Importe any inji	21. Signature of Funeral Source (1998) Signature of Funeral Home of Lemmon Funeral Home of 10 W. Padonia Rd., Time	Dulaney Valley, Inc.
	23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line.	r arrest, Approximate Interval Between Onset and Death
Physician /Medical	disease or condition resulting in death) a. Software Carrier Due to (or as a consequence of):	anths
Examiner	Sequentially list conditions, Due to (or as a surresquence of):	
Control of the state of the sta	Ti airy, leading his contained to Cause. Enter Underlying Cause, (Disease or injury	
760, 16 be executed ysician and e buriat-transit	that initiated events c. c. Due to (or as a consequence of):	
766 Pe be be cal	d	
68 rtiffica ng ph as th	W IF FEMALE:	
T: 45 Am Joy I Records, P.O. Box 68 The law requires that the death certificat lite has been signed by the attending phypage 2 should be detached for use as the completed by Physiclan/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 poinths? 1 Yes 22 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Other (specify) 9 Unknown 23c. If yes, outcome of pregnancy 1 Charles Charles Conditions contribution to death but not resulting in the underlying cause given in Part 23a. Displayed 2	23d. Date of delivery Month Day Year
P. P. that if detac	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 239. Di	d tobacco use contribute to the cause of death?
ds, Furies that is signed if the det		Yes 2 No 3 Probably 4 Unknown
I Records, I Records, The law requires: The law requires: The law been signing age 2 should be Completed by	24a. W	as an 24b. Were autopsy findings available
Rec Re lav he lav age 2	at pe	topsy prior to completion of cause of death? s 2 No 1 □ Yes 2 □ No
Vital F sicien: Th certificate riector, pag	25. Was case referred to medical 26. Place of Death (Check on	
of Vita of Nita Physicien: this certific ral director,	O 1 Yes 20 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Ciner: 4 Nursing Home 5 R	esidence 6 Other (Specify)
OG Dn of ding Phy After thii funeral c		e how injury occurred
ivision in Attending for death. irector: After the fune	2 Accident investigation 2 Suicide 6 Could not be 286 Location 286 Location 286 Location 286 Location	
U(2 2 / 0 (Division c Division c tel or Attending P is after death. Tel of the traffer ted in by the trinera Certification:	289. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	n (Street and Number or Rural Route Number, Town, State)
Hospi 24 hou Funer tely fill	29a. Certifier (Check only one) 29a. Certifier 29a	ne cause(s) and manner as stated. e, date and place, and due to the cause(s)
To the within 2 To the comple	29b. Signature and title of certifier D 58303	29d. Date signed (Month, Day, Year) APML 22 2006
10 4	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AAON CHANES, M (260) N. Charles St KRAMM M 21	
State	De Des Grad March Con Veryl	•
Registrar		
	ATR 6 0 LOOV	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2006 Year APRIL 22, **Physician** ALTSCHULL ELEANOR 9:50 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth MAY 15, 1924 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 21 F 218-12-8630 81 MD **Director** Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 23a or 28a-f show the Medical Examiner must be notified at **Funeral Director** 1 ☐ Yes 2 🔀 No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 728 KAHN DRIVE 21208 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Iteme 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No þ Specify: Specify 3 X Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) EXECUTIVE SECRETARY STATE OF MARYLAND permit. Pages 1 and 2 should be filed v Department of Heelth and Mental Hygiel Importent: if Item 27 is marked other tt eny injury or other treumatic event, the 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be HARRY HURWITZ MOLLIE KATZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 BLENFIELD COURT - PHOENIX, MD 21131 HARRIET CHENWORTH / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State SHAAREI ZION CEMETERY 04/24/2006 4 ☐ Donation 5 ☐ Other (Specify) ROSEDALE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the shock, or head failure. List only one cause on each line. Immediate Caus. (Final disease or condition resulting in death) one that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ovarian **Physician** au cur /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) ours after death.

•••• Director: After this certificate has been signed by the attending physicien filled in by the funeral director, page 2 should be detached for use as the buria by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: Be 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 은 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 17 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 🗌 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funerel C t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DS8303 W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles S+ Barrismand 21204 2006 32. Registrar's Signature 31. Date filed (Month, Day, Year) APR 2 State Registrar

Stown

PITSCAUL

1 - For State Registra
1. Decedent's
AGNE

State of Maryland / Department of Health and Mental Hygiene | | | |

19727

29d. Date signed (Month, Day, Year)

APRIL 22 2006

			1 - State Registrar			Certificate	of De	ath		Reg. No		U	1 6. / L. /
			1. Decedent's Name (First, Middle, Las	st)					2. Date of De Month	eath Da		1005	3. Time of Death
н	Physici		AGNES SELMA	ROWEN					APRIL	2	-	Year OO6	11:50 AM
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, To	own, or Loc	ation of Death		40	. County of	-	
	LXUIIII	•	HARBOUR HOSP	ITAL		BALTIMORE					N/A		
	Funeral		5. Social Security Number 6. S	ex 7. Age (/	n yrs. last birt	hday) If Under 1	Year If t	Jnder 24 Hrs.	8. Date of Bi (Month, D	rth		9. Birthpl Count	ace (State or Foreign
	Director		218 07 6203	□M 2√F 84	. \	rs. Months	Days H	ours Min.	April	10,	1922		yland
	Q		Usual Residence of Decedent										
	how		10a. State 10b. County	10	Oc. City, Town	or Location						10	Od. Inside City Limits
	Ma P-1-	cto	Maryland Anne Ar	undel	Balt:	imore							1 ☐ Yes 2 ☑ No
	or 28	Directo	10e. Street and Number			10f. Zip C	ode			_	tizen of Wh	nat Coun	try?
	1h wi	<u>a</u>	743 Old Rivers	ide Road			21225	5			U.S.		
	s 1 and 2 should be filed within 72 hours after death with the Maryland Heelth and Mental Hygiene. Item 27 is marked other then "natural", or items 23s or 28e-f show other treumatic event, the Medical Examinat must be notified at	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Decede	nt of Hispan	nic Origin? (Sp lexican, Puerto	ecify Yes or Na Rican, etc.)	0-	14. Race	- America White, e	
9	or it	F	1 Never Married 2 Married	1 ☐ Yes 2 📆 No If Yes, Give		1 ☐ Yes 2		pecify:			Specify:		
21215-0036	ours	d by	3 ☐Widowed 4 📆 Divorced	Year or Dates:							openy.	WILL	
5-0	72 h natu	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a.	Decedent's Usual (Give kind of work life. DO NOT use	Occupation done durin	g most of work	ing	16b. K	(ind of Bus	iness/Ind	lustry
21	within ene. then	d d	Elementary/Secondary (0-12)	College (1-4or 5+)	п		retired)				Own Home		_
2	filed w Hygier other th	ပ္ပ	12th		11	omemaker	1.0			14:14:			e
Maryland	d off	Be	17. Father's Name (First, Middle, Last)	er Walston			18.	Mother's Nam	aret Ri			,	
<u>ya</u>	Men Men arke	၉											
a	12 should be fi h and Menta? H 7 ie marked otl treumatic ever		19a. Informant's Name/Relationship (**		Mailing Address (-			
	s 1 and 2 of Heelth item 27		Ernie Bowen / Sc			03 Taos 1			Allen,				
ore	of H of H fiter		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □	Removal from State	20b. Place of cemeter	Disposition (Name y, crematory or oth	e of er place)	1	Date		ocation - C	•	
Ě	Pages nent of h ant: if its ury or of		4 □Donayon 5 □ Other (Specif		Bayvie	ew Cremat			/2006			_	laryland
Baltimore,	permit. Pages Department of Important: If i eny injury or one		21. Signature of Funer I Service Licer	is ee		22. Name and							C CONTRACTOR
00	89 5 8		PATE								re, N	laı y l	and 21225
			23a. First The dis or commock, or heart failure. List only	plications that caused the	e death. Do r	not enter the mode	of dying, su	uch as cardiac	or respiratory	arrest,			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ANOXIC									Onset and Death
1	/Medical		resulting in death)	Due to (or as a c			71.17						12 0/1/3
	Examiner			ARRHY	IS CVE	VTRIC	WLAR	FIBRIC	LAT	1000	1	2 DAYS	
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a c									
	uted	Examin	Cause (Disease or injury that initiated events	· ASPIRAT	ION ?	PNEUMO	NIA					1	ZDAYS
Ć.	exec n an ial-tr	Exa	resulting in death) Last	Due to (or as a c		of):							
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68	requires thet the deeth certificate be executed seen signed by the attending physicien and hould be deteched for use as the burial-transit	Medical											
ŏ	ndin use	_	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2	pregnancy	2 DEstania ara	~~~~				23d. Date		
. Bo	deeth e atte d for	ic la	in the past 12 months? 1 □ Yes 2 ☑No	4□Pregnant at tin		3 ☐ Ectopic pre 5 ☐ Other (spe					Mont	th	Day Year
P.O.	thet the deeth ce ned by the attendi	hys	9 Unknown	9□ Unknown						- 1			
т, П	w requires thet s been signed t should be det	Completed by Physician	Part II. Other significant conditions of	contributing to death but i	not resulting in	the underlying ca	use given in	Part I.	23e. Did	tobacco	use contrib	oute to th	e cause of death?
ds	auire n sig	D 0	CHRONIC ATRIAL	FIBRILLA	TION				1 🗆	Yes 2	D MO 3	∃ □ Prob	ably 4 □Unknown
S	≥ n ∾	ete	CORONARY AR	TERY DISE	ASE				24a. Wa		24b. W	ere auto	osy findings available apletion of cause of
Re		Ĕ	COCCIOTAL	1 4 100					heq	opsy formed?	_ de	ath?	
a			25. Was case referred to medical					. Place of Deal	1 ☐ Yes		11	⊒ Yes	2 No
₹	Physician: this certific ral director.	Be	examiner?	Hospital:	0 □ C D/O	tpatient 3 DOA	Other	. Place of Deal			c 🗆 Other	(C	a
ō	Phys this ral di	5	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Minpatient 28a. Date of Injury	2 ER/Ou			Inursing Ho	28d. Describe				0
UC	ding h. After fune	ig l	1 ☑Natural 5 ☐ Pending	(Month, Day Y	'ear) li	njury M	c. Injury at Work?	2 🗆 No		,			
i <u>s</u> i	Attending in death.	ca	3 Suicide 6 Could not b	e Zan Blace al Iniue	- At home, fa				28f. Location	(Street a	nd Numbe	r or Rura	I Route Number,
Division of Vital Records,	or A after Direction by	Certification:	4 Homicide determined	building, etc.	(Specify)	, ottoot, tuotoly,			City or To	own, Stat	θ)		
_	spitel or Attending Phy hours after death. Ineral Director: After this y filled in by the funeral d	a C	29a. Certifier 1 Certifying Pt	nysician: To the best of	my knowledos	, death occurred a	t the time. c	date and place.	and due to the	e cause(s	s) and man	ner as st	ated.
	5 C = >	129											

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

RUTH INDAHYUNG 3001

Indomyuna 30. Name and address of person who comfleted > se of death (Item 23a) (Type, Print)

32. Registrar's Signature

SOUTH MANOVER STREET, BALTIMORE, MD

29c. License number

RES 000

			For	State of Maryland /	•		Mental Hygie	ne	10700
			1 - State Registrer		Certificat	e of Death	Reg.	NO. UUU	12/20
	Physici	an	1. Decedent's Name (First, Middle, Last) MOFELL	BLACKWEL	1			Day Year	3. Time of Death
7	/Medic Examin		4a. Facility Name (If not institution, give s			Town, or Location of Deat	APRIL	4c. County of Death	SOLA
	Lxamiii	ei	1217 Sherid	an Avenue	$, \mid \mathcal{I}$	Baltimore	70)	,	
	Funeral		5. Social Security Number 6. Sex		inthday) If Under	r 1 Year If Under 24 Hrs Days Hours Min.	8. Date of Birth (Month, Day, Ye	ar) 9. Birth	nplace (State or Foreign
	Director		43-26-411	M 2027 86	Yrs.		09,04,	1919 N.	arolina
	land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov	vn or Location				10d. Inside City Limits
	Mary India	tor	MD	BA	ZTIM	ORE			1 Ves 2 No
	or 284	Director	10e. Street and Number		10f. Zip	Code	10g.	Citizen of What Cor	untry?
	eth wi		1217 5/1	BRIDAN AV,		2123	7	USA	7
	er de	nne		12. Was Decedent Ever in U.S. Armed Forces?	13. Was Dece	dent of Hispanic Origin? (S cify Cuban, Mexican, Puer	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White	rican Indian, n, etc.
36	urs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes ♣ No If Yes, Give Year or Dates:	1 ☐ Yes	2 No Specify:		Specify: B	LACK
21215-0036	within 72 hours after deeth with the Maryland ene. than "natural", or items 23e or 28e-f show he Medical Examiner must be notified at	Completed by Funeral	15. Decedent's Educ (Specify only highest grade	cation 16a	. Decedent's Usu	al Occupation ork done during most of wo	16b	. Kind of Business/I	ndustry
2	ithin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life DQ NOT u	se retired)	Kirig	Dat	1
	led w lygier her tr	Cor	17 February Name (First Middle 1 and)		Sea	metress	S /Fires Adiabatic Admin	Rega	J
Maryland	ntal Hed of	Be	17 Fether's Name (First, Middle, Last)	-		18. Mother's Nai	ne (First, Middle, Maid	ren Sumame)	
2	should nd Me mark mark	2	19a. Informant's ame/Relationship (Typ	De, Print) (SOM) 191	b. Mailing Address	(Street and Number of Ri	ural Route Number, Cit	ty or Town, State, Z	ip Code)
	nd 2 eith a 27 is r trau		William H. Bla	ckwell 12	47.Sh	eridan A	x Ralto	MD 212	39
ore,	es 1 a of He of Herr fitam r oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Re	aamata	of Disposition (Namery, crematory or c	me of other place)	Pate 20c	Location - City or 1	own, State
Ĕ	Pag ment tant: i		4 Donation 5 Other (Specify)	Garris	son ton	25 Kemeteri	156/00	JINGS M	IIIS, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or itams 23s or 28s-f show any injury or other traumatic avent, the Medical Examiner must be notified at each.		21. Signature of Funeral Service License	land.	Variation ar	Address of Facility	e Fruer	alserv	ices
	40240		23a. Part1. Enter the disease, or complic	cations that caused the death. Do	not enter the mor	5 YORKER	d. Balto	MO ZIZ	Approximate
	Dhoristan		shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	OBST				Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	BOWEL Due to (or as a consequence		RUCT/O	· V		days
	Examiner		Sequentially list conditions, b	ALZHEI	MERS	DISEAS	E		YES
2	Po iii	Iner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	of):				1
82	and I-trans	Examiner	Cause (Disease or injury that initiated events cresulting in death) Last	Due to (or as a consequence	of):				
8760,	ficate be executed physicien and is the burial-transit	dicalE	L.						
687	ificate g phy: as the	edic							
Вох	h cert	M/U	230. Was decedent pregnant	3c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death	n 3 ⊟Ectopic p	rean annu		23d. Date of deliv	very
0.	ures thet the death certificions signed by the attending do be detached for use as	by Physician/Me	in the past 12 months? 1 🗆 Yes 2 🖃 No	4 Pregnant at time of death	5 ☐ Other (sp			Month	Day Year
₾.	het the d by t	Phy	9 ☐ Unknown Part II. Other significant conditions con		in the underlying o	nauco givon in Part I	23e Did tobacc	no use contribute to	Ihe cause of death?
Division of Vital Records,	Attending Physician: The law requires that the death certificath: death. actor: After this certificete has been signed by the attending by the funeral director, page 2 should be detached for use as		Tarrii. Stillor digitili Satt Contactions con	tributing to doubt but not resulting	in the discensing c	ause giverrar r arti.	1 ☐ Yes		bably 4 Unknown
S	w requir been si should	lete				* * * * * * * * * * * * * * * * * * * *	24a. Was an	24h Ware aut	opsy findings available
æ	ding Physician: The lav h. After this certificete has funeral director, page 2	Completed					autopsy performed	? prior to co	ompletion of cause of
ta	ian: Trificel	BeC	25. Was case referred to medical			26. Place of De	th (Check only one)	No 1 □ Yes	2 No
>	ysici direc	To E	examiner? 1 Yes 2 No	ospital: 1 Inpatient 2 ER/O	utpatient 3 DC	Othor	lome 5 Residence	6 ☐Other (Spec	ify)
0	ng Pt		27. Manner of Death 1 Natural 5 □ Pending		Time of Injury	28c. Injury at Work?	28d. Describe how in	njury occurred	
<u>s</u>	ttendi death. for: A	cat	2 Accident investigation 3 Suicide 6 Could not be	One Blace of laine. At home 4	М	1 Yes 2 No	201		
$\overline{\underline{S}}$	after alter Dirac	Certification:	4 Homicide determined	28e. Place of Injury - At home, for building, etc. (Specify)	arm, street, lactor	у, опісе	28f. Location (Street City or Town, St	and Number or Hui ate)	rai Houte Number,
	To the Hospital or Attent within 24 hours after death To the Funaral Director: completely filled in by the		29a. Certifier 1 Certifying Phys	icien: To the best of my knowledg	e, death occurred	at the time, date and place	, and due to the cause	e(s) and manner as	stated.
	ha Ho in 24 I ha Fu pletel	Medical	(Check only 2 Medical Examin	er: On the basis of examination as and manner stated.	nd/or investigation	i, in my opinion, death occi	irred at the time, date	and place, and due	to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	-	29	c. License number	29d.	Date signed (Month	, Day, Year)
7	^		- sura sin	~ vo		100 73 2	5 4 M	prille	1,2006
	3		30. Name and address of person who co	mpleted cause of death (Item 23a)	(Type, Print)	c. License number HOD 4323	Baltin	ince MI	2/224
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	1. 1	B	7-611-11	1 - 1	
72-	Registr	ar	ADD 5 5 2	NOR Mague SE	STORE STORES				

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Earlwin L. Bowie 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day April 19, 2006 1007 hrs Medical Examiner Bowie 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deal NIA 506 E. 26th Street Baltimore 9. Birthplace (State or Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days Hours Director 02.19.1954 Country) Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits Baltimore MD 1 Yes 2 No 28a-f show once. Director 10e. Street and Number 10g. Citizen of What Country 26th Street USA 21218 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married Yes Yes, Give Year Yes 2 No specify: Widowed Divorced Specify \$ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed College (1-4 or 5+) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 72 the Medical ltimore, MD 21215-0036 other than Rooter Home Improvement ment of Health and Mental Hygiene. tant: If item 27 is marked other the or other traumatic event, the Medi 18 Mother's Name (First, Middle, Maiden Surname Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Street Eveenville NC 10ther 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town crematory or other place) Removal from State Cremation 3 04-26.06 rtant: Other permit Name and Address of Facility ompassion Figural Serv 3000 E. Baltimore Street that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician he disease, or complications Between Onset and failure. List only one cause on each I /Medical Death Heroin and ethanol intoxication and cocaine use Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical item# 23a,27,28a-f,perME,g854,4/27/06 TI X UNPENDED AMENDED Box 68760, 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I o 23e Did tobacco use contribute to the cause of death? ģ ۵. Yes 2 No 3 Probably 4 ✔ Unknown Division of Vital Records, Completed s been s 24a Was an 24b Were autopsy findings available autopsy performed' death? ✓ Yes certificate ✓ Yes 2 the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other 4 examiner? DOA FR/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene Inpatient 1 🗸 Yes ဥ 28a, Date of Injury (Month, Day, Year After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification: Natural 5 Pending Fnd 4/19/2006 Yes 2xx No Director: d in by the f Fnd 9:30 AM 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 6 X Could not be Suicide or Town, State) 506 E. 26th Street Ltimore, MD determined vithin 24 hours a House Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. April 20, 2006 MD 30 Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Ana Rubio MD. 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year)

State Registrar

Registrar's Signature ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 24, John Edward Brown April 2006 9:00AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6616 Altamont Avenue Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) June 18, 1 Birthplace (State or Foreign Country) **Funeral** Min. Days Hours **№** M 2□ F 97 Yrs. 217-14-3721 1908 Director Maryland Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits worde! permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ehow with injury or other treumatic event, it a Modical Examinar must be nuitied at once. Catonsville 1 ☐ Yes 2X No Baltimore Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 6616 Altamont Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes - 2∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Shipping Industry Ship Captain 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Edward Brown Bessie Ann Hart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6616 Altamont Avenue Catonsville, MD 21228 Alverta V. Brown, Wife 20b. Place of Disposition (Name of cometery, crematory or other place)
Meadowridge
Memorial Park Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 04/27/06 Elkridge, Maryland 21. Signature of Funeral Service Littlessee
Thomas Gregor 22. Name and Address of Facility
MacNabb Funeral Home P.A.
301 Frederick Road Catonsville, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) year **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine signed by the attending physicien and d be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown cete has been signification to page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No fo the Hospital or Attending Physician: after death.

Director: After this certific Be 25. Was case referred to medical 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be determined within 24 hours after de To the Funerel Directo completely filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Charles Kalar J 024781 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) BRANJAMOR MD, 1001 PIRE Heresto me 5300 Barrone 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 2 5 2006 ENGIAN. Registrar

			For	State of Marylar	nd / Departme	nt of Health and	Mental Hygi	ene a a a	10701
			1- State Registrar Amend ite					g. No.	12/31
	Physici	an	1. Decedent's Name (First, Middle, La	st)	1		2. Date of Death Month	Day Year	3. Time of Death
4	/Media	al	4a. Facility Name (If not institution, giv	KER-LND	ER/EI	y, Town, or Location of Dea	MPC11	4c. County of Dea	3.15 PM
Eq.	Examir	er	RIDENLIPI	1 Rd	38. 61	OPP &	/	Hart	ard
	Funeral		5. Social Security Number 6. S		last birthday) If Und	er 1 Year If Under 24 Hrs		Year) 9. Bir	thplace (State or Foreign
	Director		417-00-1909	M 2007F	2 Yrs.	Days Hours Hill	8-28-	1943 A	naryland
	land wo		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Location				10d. Inside City Limits
	Mary a-f ah	tor	mo Itari	ford 3	TOPPA				1 Yes 2 No
	or 284	Direc	10e. Street and Number	211 01	10f. 2	ip Code	10	g. Citizen of What Co	ountry?
	ath w	Funeral Director	810 toxu	KII Kd		21085		USM	
	Her de	Fune	11. Marital Status 1 Newer Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No	If Yes, sp	edent of Hispanic Origin? (secify Cuban, Mexican, Puer	to Rican, etc.)	14. Race - Ame Black, Whi	
98	ours a	þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 □ Yes	2 No Specify:		Specify: U	hite
21215-0036	within 72 hours after death with the Maryland one. than "natural", or items 23e or 28e-f ahow ha Maulgal Exertier nast be notified at	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Decedent's Us (Give kind of v	rork done during most of wo	nrking 1	6b. Kind of Business	/industry
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Maryland	2 sho		19a. Informant's Name/Relationship (Type, Print) (French	19b. Mailing Addre	ss (Street and Number or R	ural Route Number,	City or Town, State.	Zip Code 22936
	iges 1 and 2 should be filed within 72 hours after death with the Marylar it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic avent, the Madical Exarchise mast be notified at		20a. Method of Disposition	Jenkins	Place of Disposition (N	+ OXTICO	Date 1	Oc. Location - City or	Town, State
nor	Pages nent of I int: If Its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State	cemetery, crematory of	other place)	18201		-11 00
Baltimore,	当日を言う		21. Signature of Funeral Service Licer	110	22. Name	and Address of Facility	ians fur	real che	275
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)	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	. ADRENAL	CANC	ek			2 weeks
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Вох	death certifica e ettending ph id for use as t	M/U	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn		ôreanancy		23d. Date of de	
О. В	e deat	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of o				Month	Day Year
a	The law requires that the death certifica ete hes been signed by the ettending ph page 2 should be delached for use as it		Part II. Other significant conditions	contributing to death but not res	sulting in the underlying	cause given in Part I.	23e. Did tob	acco use contribute to	o the cause of death?
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	To the Hospitel or Attending Physicien: within 24 hours elter death. To the Funeral Director: After this certific completely filled in by the funeral director,	edicai	29a. Certifier (Check only one) 1 ✓ Certifying Pl 2 ☐ Medical Exer	nysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occurre ation and/or investigation	d at the time, date and placen, in my opinion, death occ	e, and due to the ca urred at the time, da	use(s) and manner a te and place, and du	s stated. B to the cause(s)
	To the within 2 To the complex	Me	29b. Signature and title of certifier	and marrier states.	2	9c. License number	29	d. Date signed (Mon	th, Day, Year)
	1		· /			738048	4	4/20/00	
	0		30. Name and address of person who	completed cause of death (Iter	m 23a) (Type, Print)	0	1	000	
	7	•	Dr. Goldman 31. Date filed (Month, Day, Year)	9106 Phil	edephia	Rd. DOS	eache pr	D alg	3_/
	Sta Registr		APR 2 5 21	life .	k Scarles		1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year **Physician** LS BURROWS ARA PRIL 2006 /Medical 4c. County of Death Facility Name (If not institution, give street Town, or Location of Death Examiner andallstown If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State Country) 5. Social Security Number **Funeral** 219-70-6283 Months Days 1□M 2 F Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10c. Oity Town or Location 10b. County 10d. Inside City Limits or 28a-f show ir than "natural", or items 23a or 28a-f sho The Medical Examinar must be notified at 1 Yes 2 No **Funeral Director** saltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21 Peges 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S. Amed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Blac þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during hife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Callage (1-4or 5+) Elementary/Secondary (0-12) ountan ilth and Mental Hygiei 27 is marked other tit raumatic event, III. Sather's Name (First Middle, & Name (First, Middle, Maiden Su Be . Informa 's Name/Relationship (Type, P nt) Fural Route Number, City or Town, State, Zil Code) 19b. Mailing Address (Street and Number f Health airte stown MD 2
20c. Location - City or Town, State 21133 Dadie ō <u>=</u> 5 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Depertment of Important: if eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal re if Fune a Service Licensee Services 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner rferates Sequentially list conditions, I any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consuluence of Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed Reinal Children Tu 444 Due to (or as a consequence of): physicien a s the burial-t P.O. Box 68760 Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) by the stached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ should b 3 Probably 4 Unknown 1 □ Yes 2 □ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an hes autopsy performed? page certificete 1 ☐ Yes 2/2 No : After this certifical funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ٩ 1 ☐ Yes 2 Z No 2 ER/Outpatient 1_Inpatient 3 DOA 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funerel Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 9 cleans 029085 23 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 00 21153 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			1- For State of Maryland / Department of Health and N Certificate of Death		ene 0 0 6	12733
	Physici /Medi		1. Decedent's Name (First, Middle, Last) James William Brown	2. Date of Death	2006 Year	3. Time of Death / 12:19A M
	Examir		42 Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Towson		4c. County of Deal	imore
	Funeral Director		5. Social Security Number 6. Sex 12 F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	9. Birth	nplace (State or Foreign untry)
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2 Kown altimore	0 0 = b		20a. Method of Disposition 1 ABurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Date 20	c. Location - City or T	Town, State
Balt			21. Signature of Furreral Service Licenses Variance of Furreral Service Licenses R72 Cibertu Ra.	ra Fune Randalle	ral Sen	M 44
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	or respiratory arrest		Approximate Interval Between Onset and Death
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3760,	ite be iysicie ne bur	licai Ex	resulting in death) Last Due to (or as a consequence of): d			<i>J</i>
Division of Vital Records, P.O. Box 60	Attanding Physician: The law requires that the death certifica refeath. closth. sctor: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the	Completed by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown		23d. Date of delive Month	very Day Year
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ب	Hoapita 4 hours Funeral	Medical Ce	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place (Check only one)	, and due to the caus rred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the	Me	29b. Signature and title of certifier 29c. License number		Date signed (Month	
	M		30. Name and address of person who completed cause of death (Item 23a) (Type, Print). W. A. R. Ley GAM 6701 N. Charles St.	Balto	12 ill9	16
	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature	17 0010.		/
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State State Amend #2 Per Phy G855 5/09/Sertificate of Death Reg. No. 2. Date of Deat 4-19-Month Day Decedent's Name (First, Middle, Last) -2006 3. Time of Death **Physician** Brown 109N /Medical (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MAN Aroutus If Under 1 Year | If Under 24 Hrs. B. Date of Birth (Month, Bay, last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 218-62-8950 1 ☐ M 2 🕶 F Director Japan Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits •how 10a. State City, Town or Location ns 23a or 28a-f ehor 1 Yes 2 No **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2120 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, Wh e, etc other traumatic event, If a Mudicul Exandran 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 No Specify: Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working line. DO NOT use retired 15. Decedent's Education (Specify only highest grade completed) s 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 ie marked other then dany (0-12) College (1-4or 5+) Domes-Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 46anosu Viesa 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9/16 3807 Arou. 20b. Place of Disposition (Name of cometery, crematory or other place 20a. Method of Disposition Date 5 <u>=</u> 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 Removal from State ö Department of Important: If eny injury or once. 21. Sign tur of Funer Strvice Licensee MD 21133 la tours 23a. Part1. Enter the desease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** can /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner sician and burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Inknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 1 Yes or Attending Physician: To Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 1 Yes 2 No 1 🗌 Inpatient 5 esidence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 57088 who completed cause of death (Item 28a) (Type, Print) 1 md Dalt min 31. Date filed (Month, Day, Year) 32 Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

2006

			1 - For State Registrar	State of Marylar		artment <i>rtificate</i>			d Mental H	ygiene Reg. No.	006	12735	
			Decedent's Name (First, Middle, Last))		2. Date of De							
	Physici		Stephen Lew	is Burley					April		Year 2006	5 · 5/1 P M	
	/Medio Examir		4a. Facility Name (If not institution, give			4b. City, Town, or Location of Death							
			Union Memorilal H	lospital		Baltimore					n/a		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1		If Under 24 h		lirth	9. Birth	pplace (State or Foreign	
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	pu &		Usual Residence of Decedent 10a. State 10b. County	10c C	ty, Town or Lo	ontion						404 (-14, 0)	
	sho	5	MD Baltimo		Cockey							_	
	28a-1	Director	10e. Street and Number		Juckey		Pa da			10- 00	(110 + 0		
	with	늅	219 Warren Rd.			10f. Zip (10g. Citiz		untry?	
	eath me 23	Funeral		12. Was Decedent Ever in U	IS 13 1	210		nanic Origin?	(Specify Yes or N	lo. 1	Day Year 18 2006 5:54 P 4c. County of Death n/a Year) 9. Birthplace (State or Fore Country) 10d. Inside City Lim 1 Yes 2 N 20g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: White 8b. Kind of Business/Industry Pepsi Bottling Group faiden Surname) 1 Lowery City or Town, State, Zip Code) MD 21030 Oc. Location - City or Town, State Sparks, MD Pulaney Valley, Inc. Imp. MD 21093 St. Approximate Interval Between Onset and Death Onset and Death 2db. Were autopsy findings availal prior to completion of cause of death? 2 No 3 Probably 4 Unknown Onset and Death 2 No 3 Probably 4 Unknown Onset and Death 2 No 3 Probably 4 Unknown Onset and Death 2 No 3 Probably 4 Unknown Onset and Death 2 No 3 Probably 4 Unknown Onset and Death 2 No 3 Probably 4 Unknown Onset and Death 2 No 3 Probably 4 Unknown Onset and Death 2 No 3 Probably 4 Unknown Onset and Death 2 No 3 Probably 4 Unknown Onset and Death 2 No 3 Probably 4 Unknown Onset and Death 2 No 3 Probably 4 Unknown Onset and Death 2 No 3 Probably 4 Unknown Onset and Death 2 No 3 Probably 4 Unknown Onset and Death 2 No 3 Probably 4 Unknown Onset and Death 2 Deat and Number or Rural Route Number, State) 3 No 3 Probably 4 Unknown Onset and Death 2 Deat and Number or Rural Route Number, State) 3 Deat and Number or Rural Route Number, State) 3 Deat and Number or Rural Route Number, State)		
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Ą	within 72 hours after death with the Maryland ene. Iten "naturel", or itame 23a or 28a-f show he Medical Exami or must be notified at	Completed	15. Decedent's Edu		16a. Dece	dent's Usual	Occupati	ion		16b. Kin	d of Business/I	ndustry	
Maryland 21215-0036	Pn "n	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use	retired)	ring most of	working				
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덜	a Hygie t other	Be (17. Father's Name (First, Middle, Last)				1	8. Mother's 1	Name (First, Middle			<u> </u>	
<u>a</u>	ould be Mental arked o	T _o	Lewis Mark Burle	У				Rosell	a Elizab	eth Lo	owery		
a L	E PEE		19a. Informant's Name/Relationship (Type	pe, Print)	19b. Mailir	ng Address (Street an	d Number or	Rural Route Num	ber, City or	Town, State, Z	ip Code)	
≥	and ealth n 27		Adrienne G. Burl					d., Co	ckeysvil	le, Mi	D 21030		
9	permit. Pages 1 and 2 to Department of Health ar Important: If tem 27 is any injury or other traugus.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R		Place of Dispo cemetery, crer	sition (Name matory or oth	of er place)	ц/	21/06	20c. Loc	ation - City or 1	Town, State	
Baltimore,	Pag ment ant:		4 □Donation 5 □Other (Specify)	Je	essops	United	d Me	thodis	t Ch.Ce	m. Sr	arks.	MD	
<u>=</u>	pparti		21. Signature of Funeral Screen License		22	2. Name and	Address	of Facility					
ш_	201		Michael J	lagle	10	W. F	ador	nia Rd	Timor	nium.	ney va MD 210	ney, inc.	
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only on	cations that caused the dea ne cause on each line.	th. Do not ent	er the mode	of dying,	such as card	diac or respiratory	arrest,		Approximate	
ı	Physician		Immediate Cause (Final disease or condition	M	VOCA	ROLA	1_	INF	ARCTIO	N		Onset and Death	
	/Medical	_	resulting in death)	Due to (or as a consec	juence of):	1 V (1)		(14)	7711-10	·			
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8760,	cian cian surial			Due to (or as a consec	(uence or):				,				
8	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai											
9 ×	res that the death certific igned by the attending p be detached for use as	0	IF FEMALE:	20 If you system of second									
Box	atten for us	lan	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregn. 1 ☐ Live birth 2 ☐ Feta	ıl death 3 ☐	Ectopic pre				23			
o.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of o 9□Unknown	leath 5∟	Other (spec	:ify)					,	
<u>.</u>	that the	by Physician/M	Part II. Other significant conditions con	tributing to death but not res	ulting in the ur	nderlying cau	ISA GIVAN	in Part I	23e Did	tobacco us	e contribute to	the cause of death?	
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Division of	after after Dire	E	4 Homicide determined	building, etc. (Special	y)	eer, raciory, r	Jilice			wn, State)	Number of Aut	ar Hobie Wunder,	
	To the Hospital or Attending Physicien: within 24 hours after death To the Funeral Director. After this certific completely filled in by the funeral director.		29a. Certifier Certifying Phys	ician: To the best of my kno	wledge death	occurred at	the time	date and nis	ece and due to the	cause(s) o	nd manner an	stated	
	24 h 24 h Fui etely	Medical	(Check only 2 Medical Examinations)	ner: On the basis of examina and manner stated.	ition and/or inv	vestigation, in	my opin	ion, death o	courred at the time	, date and p	place, and due t	to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	\		29c. I	_icense n	umber		29d. Date	signed (Month,	Day, Year)	
	1			1			0	5023	32	4/70/10			
al			30. Name and address of person who col	mpleted cause of death (liter	n 23a) (Tvne	Print)		ite 31			11 0011	ν	
4	9		CYRLS HAMI						z Rd., Sp	ء ماء د	MD 21	150	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	47		uyer	JOUK	<u>, sp</u>	arks,	WID 21.	124	
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Nancy L. Boyle State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Time of Death Month Day April 23, 2006 Medical Examiner Lee Bov1e 0040 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore N/AGood Samaritan 8 Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Funeral 217-40-3189 Months Days Hours Min Director 62 08/28/1943 Mary land 1 M 2 X X Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County in 10a. State 1 X XYes 2 No N/A 28a-f show Maryland Baltimore Pages 1 and 2 should be filed within 72 hours after death with the Maryland rment of Health and Mental Hygiene.
 rtant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country' 223 East Northern Parkway Apt B USA 21212 ā Funera 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X X Married Yes 2 XX No White 1 Yes 2 No specify f Yes, Give Year Divorced Widowed Specify 2 or Dates 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical Baltimore, MD 21215-0036 12 Psychologist Medical 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) å Clifford Myrtle Author Busard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas J. Boyle 223 East Northern Parkway Apt B Balto. MD 21212 Husband 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Metro Crematory Burial 2 xxCremation 3 Removal from State 4/25/2006 Catonsville, Maryland Donation 5 Other Specify: 2 Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland 21. Signatur of Funeral Service Lice Part. Enter the disease, or complication failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and /Medical Death a. Hyperglycemic coma complicating atherosclerotic cardiovascular disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed and ysician burial -UNPENDED AMENDED ian/Medi Division of Vital Records, P.O. Box 68760, attending phys or use as the bu IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year Fetal death past 12 months? Pregnant at time of death Physici 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed' death? Yes 2 🗸 No Yes 25. Was case referred to medical 26.Place of Death (Check only one) To the Hospital or Attending Physician: Be Other 4 examiner? Hospital: 1 Inpatient 2 🗸 ER/Outpatient 3 Nursing Home 5 Residence 6 Other After this 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Pending Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started cal within 2 To the 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 23, 2006 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar APR 2

			. For Sta	te of Maryland /	Department of H	Health and M	lental Hygie	ene o	10707
		4	State Registrar		Certificate of			ZNO.UU6	12/3/
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Roy William	Clark	,		April o	20, 2004	3. Time of Death A
	Examin		4a. Facility Name (If not institution, give street a	and number)	4b. City, Town, o	or Location of Death		4c. County of Death	١
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last b	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Birtl	hplace (State or Foreign untry)
4	Director		417-26-5385 1MM 2	87	Yrs.		Oct. 9,1	918 VI	rginia
2	how		10a. State 10b. County	10c. City, Tov	wn or Location				10d. Inside City Limits
of School	28a-f a	Funeral Director	Voryland V/7 10e. Street and Number	1 80	Utimore 10f. Zip Code	<i></i>	100	. Citizen of What Co	1 XYes 2 □ No
1	23a or	al Dir	3912 Dorches	ter Rd	212	15		USI	A'
X	Iteme	uner	11. Marital Status 12. Wa	is Decedent Ever in U.S. ned Forces? [Yes 2 No	13. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Bfack, White	
936	rai', or	by	. IFY	es, Give ar or Dates:	1 ☐ Yes 2 🕱 No	Specify:		Specify: B	acK
15-00	"natur	ietec	15. Decedent's Education (Specify only highest grade comp		 Decedent's Usual Occup (Give kind of work done life. DO NOT use retire 	pation during most of work d)	ing 16	b. Kind of Business/	ndustry
212	giene.	Completed	Elementary/Secondary (0-12) Co	llege (1-4or 5+)	Teache	er		Educe	ation
and	ntal Hy ad oth	Be	17. Father's Name (First, Middle, Last)	~ K		18. Mother's Nam	e (First, Middle, Ma T I O	iden Sumame)	10
Maryl	and Me and Me and Me	To	19a. Informant's Name/Relationship (Type, Pri	nt) (Niece) 19	b. Mailing Address (Street	and Number or Rur	al Route Number, C	City or Town, State, Z	ip Code)
Z S	iealth aim 27 li		MS Denise Cha	appella	of Disposition (Name of	=11amo	nt St.	Balton c. Location - City or	<u>Nd, 21214</u> Town, State
nor	ages ent of h ht: If itu y or of		1 Mariat 2 □ Cremation 3 □ Remova 4 □ Donation 5 □ Other (Specify)	comet	ery, crematory or other pla		5/2001	Balto	Md
#3/ Baltimore	permit. Fages I and 2 should be feed within 72 hours after beach with the watyful permit. Pages I and Aental Hygiene Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avent, the Madical Exending must be notified at once.		21. Signature of Funeral Service Licensee	y) ,	22. Name and Addre		uneral l	tome, P.A.	1 100
F =	105 a a	9	23a. Part Enter the disease, or complication:	s that ca used the death. Do	2222 W. N	orth Ave			Approximate
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Division of Vital Records,	To the most page of wareining ripercent. The ray within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be	. Place of Injury - At home, I]Yes 2□No	28f. Location (Stree City or Town,	et and Number or Ru	ral Route Number,
يَّ مَ	rat Dira		4 Homicide	building, etc. (Specify)					
3	E Fune Fune letely fi	Medical	(Check only 2 Medical Examiner: O	To the best of my knowledge on the basis of examination a and manner stated.					
· ·	within To th comp	Me	29b. Signature and title of certifier	agui MD	29c. Licens	se number LG 748	290	Date signed (Month	n, Day, Year)
	(0		30. Name and address of person who complete					120/20	
	Ψ		ANIL LIBGADI	4419 F	ALLS RO	BAU	COMD	21211	
	Sta Registr		31. Date filed (Month, Day, Year) 4 (30) 0 (APR 2 5 2	32. Registra s Signature	it species	•			

Barbara Collins

06-02717 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Time of Death Medical Examiner 1530 hrs Barbara Collins April 19, 2006 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** oreign Director Months Days Hours Min 367-30-8711 74 07/11/1931 1 M 2 X F Country) ΜŢ Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits items 23a or 28a-f show ust be notified at once. Anne Arundel Maryland Pasadena Yes 2 X No Director hours after death with the Maryland 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 231 Armstrong Lane 21122 USA Funera 13 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, Armed Forces? White, etc. 1 Never Married 2 Married 1 X Yes 3 X Widowed f Yes, Give Year Divorced 1 Yes 2 X No specify: White ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life DO NDT use retired) Pages I and 2 should be filed within 72 horn of Health and Mental Hygiene.
ant: If item 27 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) 2 Dept. of Defense 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be John Beger Helen Pasinski 19a. Informant's Name/Relationship (Type, Print.) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Coleen Collins (daughter) <u>1664 Millersville Rd., Millersville, MD 21108</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, permit Pages la Department of He Important: If ite injury or other th crematory or other place) April 2006 Donation 5 Othe Maryland Veterans Cem Crownsville, Maryland 21. Sign ture of Funeral 3 22. Name and Address of Facility Stallings Funeral Home, P.A. <u>3111 Mountain Road, Pasadena, MD 21122</u> mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval Between Onset and failure. List only one cause or /Medical Death Immediate Cause (Final disease Exsauguination ⊂xaminer or condition resulting in death) Due to (or as a consequence of): Bronchoscopic procedure complicated by metastatic non-small cell lung carcinoma and rulm nary aspercillus infection Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical X UNPENDED AMENDED item#23a-b,27,28a-f,perME,g855,5/11/06 TT attending physician for use as the burial Division of Vital Records, P.O. Box 68760. IE EEMALE 23d. Date of delivery 3b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Day Year past 12 months? 2 Pregnant at time of death Other (Specify) 1 Yes 2 V No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy After this certificate has prior to completion of cause of performed? ✓ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 / Inpatient 2 Other₄ ER/Outpatient 3 DOA Nursing Home 5 1 🗸 Yes 2 No Residence 6 Other 28d. Describe how injury occurred subject expired 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Natural Director: d in by the f 5 Pending 1 Yes 2xx No 4/19/2006 3:30 PM during a diagnostic procedure 2 X Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) Balto, Wash, Medical enter Glen Burnie, MD (Specify) hospital Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical To the 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 22, 2006 30. Name and address of person who completed cause of death (Item 23a) Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) State 32 Registrar's Signature Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene - Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year William Garnett Conner, Sr. April 23, 2006 4:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 725 Snowfall Way Westminster Carroll If Under 1 Year If Under 24 Hrs. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Yrs Director 80 219-18-5647 1925 MD Usuel Residence of Deceden 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1 Yes 2 No Directo Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 725 Snowfall Way ie marked other than "natural", or items 23a 21157 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 □ No1943 If Yes, Give Year or Dates: 1946 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White <u>\$</u> Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Printer **Printing** 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: if Item 27 is marked oth eny linity or othar traumatic event 2008. Robert Malcolm Conner Laura Virginia Lehnert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 725 Snowfall Way Westminster, MD 21157 Marjorie A. Conner - Wife 725 Snowfal

20a. Method of Disposition

1 □ Burial 2 ⊕ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory In

22. Name and Address of Facility Inc.4-24,06 Baltimore, MD 21. Signature of Funeral Service Usensee Cremation Society of Maryland, Inc.

23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Immediate Cause (Final Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** month conagea /Medical nsequence of): Due to (or as a Examiner S- uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine anding physician and use as the burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of defivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ŏ Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ned by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2D No 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 MResidence 6 ☐ Other (Specify) 2 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funeral Direct completely filled in by 4 Thomicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) 29c. License number 26385 Westminster 31. Date fifed (Month, Day, Year) State APR 2 5 2006 Registrar

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		_	For State Registrar	Certificate of D		1. No: UU5 12/4U
	Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Las 4a. Facility Name (If not institution, give	ances Curtis	2. Date of Death Month Location of Death	Day Year 9.00 A M 4c./County of Death
	Funeral Director		5. Social Security Number 6. S 2/2-2/-93-2 1 Usual Residence of Decedent	α	If Under 24 Hrs. 8. Date of Birth (Month, Day, 1)	(ear) 9. Birthplace (State or Foreign Country) 928 Maryland
	deeth with the Maryland me 23a or 28a-f ehow rmust be notified at	tor	10a. State 10b. County	Baltmore		10d. Inside City Limits 1, ✓ Yes 2 ☐ No
	ith with the 23a or 28	ai Director	10e. Street and Number) ay St. 311 2/3	301	g. Citizen of What Country? USA
5/5	ours after dee al', or Iteme Examiner m	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No	panic Origin? (Specify Yes or No- , Mexican, Puerto Rican, etc.) Specify:	14. Race - American Indian, Black, White, etc. Specify: White
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re, Mary	1 and 2 shi Health and tem 27 is m		19a. Informant's Name/Relationship (1)	Melke P.O. Box 5	nd Number or Rural Route Number, of	City or Town, State, Zip Code) Oc. Locafion - City or Town, State
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P.O. Box 68	law requires that the death certifica as been signed by the attending ph 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
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ion of	Attending Phy. r death. ector: After this by the funeral d	ation; To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury (Month, Day Year) 28c. Injury Work:	4 Nursing Home 5 Presiden	
Divisi	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
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	To the within 2 To the complet	Σ	29b. Signature and title of certifier A	29c. License	1697 A	1. Date signed (Month, Day, Year) RNUL 21, 2-606
	12		FAUSTO Q.	ompleted cause of death (Item 23a) (Type, Print)	organd RD.	BALTO, ND2123
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 5 20	32 Registrar's Signature		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** LURENCE 006 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE
If Under 1 Year | If Under 24 Hrs. GENESIS AUEN TIMERE -OCH 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 F Yrs 212-22-6925 MARYLAND Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28e-f ehow the Medical Examiner must be notified at BALTIMORE 1 Yes 2 No MD BALTIMORE Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21234 8720 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2 ☐ No Specify: Specify ģ 3 ₩idowed 4 Divorced WHITE "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Il Hygiene. other than TEXTICES TAILOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be if Department of Health and Mental H Importent: if item 27 is marked oft any injury or other treumstic even 00c. Be JOHN DIETZ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relatieoship (Type, Print) 270 ARKUILLE mo KOSEMARY TIANOWSKI -DAUGHROC APRIL 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place)

VANS

CHAPEL - 13EL AI 1 Burial 2 Cremation 3 Removal from State CHAPEL 25, 2006 FOREST HILL 4 □ Donation 5 □ Other (Specify) BEL AIR HARFORD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8800 PARKUILLE MO 21234 TUNERAL 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) UMMIG **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 [2] No 24a. Was an autopsy performed 20 No within 24 hours after death.

To the Funaral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🔲 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier au AULHOU

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

APR 2 5 2006

32: Registrar's Signature

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		•	For State Registrar	Otato of im	-	Certificate					Reg. No.) [6146
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	deeth with the Maryland me 23a or 28a-f ehow r must be notified at	Funeral		2. Was Decedent	Ever in U.S.	13. Was Deced		ispanic Orig	gin? (Spe	cify Yes or No			can Indian,
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Maryland	C1 (0 == 0		19a. Informant's Name/Relationship (Typ								er, City or Town, S		
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Baltimore,	m 0 - L		1	emoval from State	1	Disposition (Nar. y, crematory or o							
			21. Signature of Funeral Service License		Bel Al	r Mem. (4/24 y M		Bel Air, Funeral		_
ä	permit. Departr Importa eny inj		Itelly and	vers		1317	Coke	sbury					and 21009
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	To the Hospital or Attending Physician: The law requires that the deeth certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ellending phy completely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier Certifying Phys										
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	To wit		29b. Signature and title of certifier			200			1127		1		
7	. 0		30. Name and address of person who co	mbleted cause of	death (Item 22a) /	Type Print)	100	N57	423	/	April 2	<1,	(006
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Yeld	Sta	ate	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	carted							
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			For State Registrar	State of Mary	-	artment of F rtificate of		R	leg. No.	06	12743
25	Physici	an	1. Decedent's Name (First, Middle, Las					2. Date of Dea Month	Day	Year	3. Time of Death
	/Medi	cal-	4a. Facility Name (If not institution, give	SSEVIY		4b City Town o	r Location of Death	4	4c. C	OUP ounty of Death	10137
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400	Funeral	V	5. Social Security Number 6. Se		yrs. last birthday,		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day		9. Birth	place (State or Foreign
1	Director		216-20-5243	ØM 2□F	78 Yrs.	World Days	Tiodio IVIIII.	10/5/1	1927		YLAND
	land wo		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or L	ocation					10d. Inside City Limits
	Mary -f ehr	tor	PA CHESTER	₹	LINCOLN	UNIVERS	ITY				1 ☐ Yes 2 No
	h the	lrec	10e. Street and Number			10f. Zip Code			10g. Citize	n of What Cou	intry?
	23a c	ralD	2776 BAKER DRIVE			193				SA	
336	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at	Completed by Funeral Director	11. Marital Status 1 □ Never Married ② Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1X Yes 2 No If Yes, Give Year or Dates: Www		Was Decedent of H If Yes, specify Cubin 1 ☐ Yes 2 ☐ No	dispanic Origin? (Spe an, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)		. Race - Amer Black, White pecify: WH]	, etc.
215-0036	72 hou	ted	15. Decedent's Ed (Specify only highest grad			dent's Usual Occup	pation during most of working	na .	16b. Kind	of Business/I	
21	within 7 iene.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	`life.	DO NOT use retire		.9			
121	Hygier Hygier Ather (f		12TH GRADE 17. Father's Name (First, Middle, Last)		ENC	INEER	18. Mother's Name	(First Middle	-	LTIMORE	E CITY
Maryland	ould be f Mental H arked of	o Be	JOHN CASSERLY						.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	amamo)	
Σ	should nd Men marke imaric	ို	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mail	ng Address (Street	ALICE S		r, City or T	own, State, Zi	ip Code)
ž			BERNARD CASSERLY,	SON	983	SUNSET VA	ALLEY DR.	SYKESV	ILLE	, MD a	21784
J.e.		1	20a. Method of Disposition 1 XBurial 2 Cremation 3		Ob. Place of Disp cemetery, cre	osition (Name of matory or other pla		ate	20c. Loca	ition - City or T	own, State
Ë	mit. Pages bartment of I cortant: If its injury or o		4 □ Donation 5 □ Other (Specify)		MEM. PAR				ENDALE,	
Baltimore	permit. Page Department of Important: If any injury or ang injury or		21. Signature of Funeral Service Licen	Hay	/ 8	521 LOCH	RAVEN BLV	D. TOW	SON,		ICME, P.A. 1286
1			23a. Fart1. Enter the disease, or comp shock, or heart failure. List only	lic rions that caused the one cause on eath line.	death. Do not en	ter the mode of dyir	ng, such as cardiac o	r respiratory arr	rest,		Approximate Interval Between Onset and Death
	Physician	4	Immediate Cause (Final disease or condition resulting in death)	a aspirat	in one	Umore	à				Onset and Double
	/Medical Examiner		Tesularing in dealth)	Due to (or as a co	nsequence of):						
*	37 ₩ ,	e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a co	nsequence of):						
V	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C							
ó	be executed ician and burial-transit		resulting in death) Last	Due to (or as a co	nsequence of):						
3760,	ate be hysici he bu	Ical	(d							
89 x	entifica ling pl	Med	IF FEMALE:								
P.O. Box	es that the death certificate be executed igned by the attending physician and be detached for use as the buriat-transit	Completed by Physiclan/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	⊒Ectopic pregnanc □ Oth <i>er (specify)</i>	у		23	d. Date of deliver Month	very Day Year
	requires that the leen signed by th hould be detache	y P	Part II. Other significant conditions of	1	ot resulting in the i	inderlying cause giv	en in Part I.	23e. Did to	bacco use	contribute to	the cause of death?
rds	w require been sig should b	ed b	PArkinsma	disease				1 🗆 Y	es 2	No 3□Pro	bably 4. Unknown
Records,	ding Physician: The law re h. After this certificate has be funeral director, page 2 shc	omplet						24a. Was a autop: perfor	med?	24b. Were aut prior to c death? 1 □ Yes	opsy findings available ompletion of cause of
/ita	cian: artifica ictor, i	BeC	25. Was case referred to medical examiner?				26. Place of Death	(Check only or	10)		
) (Physician: this certific ral director,	ဥ	1 ☐ Yes 2 € No		2 ER/Outpatie	III 3 DOA	ner: 4 ☐ Nursing Hor				ıfy)
Division of Vital	Attending F r death. ector: After by the funera	Certification:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1	Yes 2□No	28d. Describe h			
Divi	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely titled in by the	Certifi	4 Homicide determined	building, etc. (S	pecify)			City or Tow	n, State)		ral Route Number,
	the Hoep nin 24 hou the Fune apletely ti	ledical	(Check only 2 Medical Examone)	ysician: To the best of my iner: On the basis of exa and manner stated.	y knowledge, dea mination and/or ii	ivestigation, in my o	ppinion, death occurr	ed at the time, o	date and p	lace, and due	to the cause(s)
	To To Corr	Σ	29b. Signature and title of certifier		0-	29c. Licens		2		signed (Month	
	1		13mm	Walet	DO		0067821		4	122/0	16
	121		30. Name and address of person who	completed cause of death	(Item 23a) (Type	Print)	Elktm	MAN 2	191	1	
	St	ate	31. Date filed (Month, Day, Year)	32. Projetrar's			SIMIL	1710	1 0	1	
	Regist		ADD 2 5 20	06	K	mark					
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DHMH 17 Rev 1/2001

ORIGINAL

or other traumatic event, the Maulical Examinar must be natified at consideration or other factor. To Be Completed by Funeral Director	Helen 4a. Facility Name (I Chapel 5. Social Security N 216-24- Usual Residence of 10a. State MD 10e. Street and Nur 1187 11. Marital Status 1 Never Marr XIXWidowed	Decedent 10b. County Howard 0 Ramsbu	rouse street and number) rsing Ho 7. Age 7. Age RT 12. Was Decedent Ev Armed Forces? 1 1 Yes XXX	ome (In yrs. last birthday) 11 Yrs. 10c. City, Town or Lo Marriot	Randa If Under 1 Year Months Days coation ttsvill 10f. Zip Code	or Location of Death 11stown If Under 24 Hrs. Hours Min.	2. Date of De Month April	22 dc	2006 . County of Deat	nore hplace (State or Foreignatry)
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ctor	216-24- Usual Residence of 10a. State MD 10e. Street and Nur 1187 11. Marital Status 1 Never Marr XIXWidowed (Special	Decedent 10b. County Howard nber O Ramsbu	arg Rd.)1 Yrs. 10c. City, Town or Lo Marriot	Months Days cation ttsvill 10f. Zip Code	Hours Min.	(Month, Da	22,	1915Mar	10d. Inside City Limit
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mpieted by Fu	XXWidowed (Spec		1 ☐ Yes XXNo	0 0.0.	Was Decedent of I	Hispanic Origin? (S van, Mexican, Puert	pecify Yes or No)-	14. Race - Ame	
mpietec			If Yes, Give Year or Dates:		1 ☐ Yes XX No		o moan, etc.)		Black, White	white
mpidu		15. Decedent's Edu	cation e completed)	16a. Dece	dent's Usual Occup	pation during most of wor	kina	16b. K	ind of Business/	Industry
	Elementary/Seco		College (1-4or 5+)			during most of wor ad)				
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Be		(First, Middle, Last)	de Matha			18. Mother's Nan				
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ai Examiner	Immediate Cause disease or conditic resulting in death) Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death)	nditions, introducte rhying injury	Due to (or as a Due to (or as a c.	consequence of):	1001 8	1000 1 10	}			30 minute
ician/Medica	IF FEMALE:		J.					1		
by Physician/Medic	23b. Was deceden in the past 12 1 Yes 2 9 Unknown	mooths?	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir	Fetal death 3	Ectopic pregnanc Other (specify)	у			23d. Date of deli Month	ivery Day Year
	Part II. Other signif	icant conditions co	ntributing to death but	not resulting in the u	nderlying cause gr	ven in Part I.	23e. Did t			the cause of death?
Completed							24a. Was	osv	prior to d	topsy findings availab completion of cause of
To Be Compi					_		1 ☐ Yes	2 No	death? 1 ☐ Yes	2 🗆 No
Be	25. Was case refer examiner?	/	1 4.1		l a	26. Place of Dea	th (Check only o	one)		
	1 ☐ Yes 2 ☑	INO		2 ER/Outpatien	IL 3 DOA		ome 5 🗆 Resid	dence	6 ☐Other (Spec	oify)
Certification:	27. Manner of Deat 1 Actural 2 Accident	5 Pending investigation	28a. Date of Injury (Month, Day)	(rear) 28b. Time of Injury	Wo	ryat rk?]Yes 2 ☐No	28d. Describe	how inju	ry occurred	
Certific	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Injun building, etc.	/ - At home, farm, str (Specify)	eet, factory, office		28f. Location (: City or Tox			iral Route Number,
completely filled in by the Medical Certifical	29a. Certifier (Check only one)	1 Certifying Phy 2 Medical Exami	sician: To the best of ner: On the basis of e and manner state	xamination and/or in	h occurred at the ti vestigation, in my	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s date and) and manner as d place, and due	stated. to the cause(s)
₹ 2	29b. Signature and	title of certifier			29c. Licens	se number		29d. Da	te signed (Monti	n, Day, Year)
) No	an Ba	lett, M.	?	1700	58670	3	AD	1124	1,2006
		ess of person who co	ompleted cause of dea	ith (Item 23a) (Type.	Print)			-		
State	31. Date filed (Mon		32. Registrar							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AMonth Audrei Year **Physician** telle 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Square 6. Sex Hospital timore 24 Hrs. 8. Date of Birth A(Month, Day, April 1), urity Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 214-44-4939 1 M 2 MF Months Hours Director Virginia 1941 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f show s 1 and 2 should be filed within 72 hours after deeth with the Maryla of Health and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23e or 28e-f show other traumatic event, the Medical Examinat must be notified at Baltimore Baltimore 1 Yes 2 No Maryland Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Fleming 21222 States nited 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give,
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2DNo Black Specify Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Grocery ashier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Depertment of Health and Menta Important: If item 27 is marked eny injury or other traumatic eveny injury or other traumatic evens. Black Henry Hamilton ၉ anie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21222 Fleming Drive -innard Cheese-Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) April Date 28 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Baltimore, Maryland Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2006 21. Signator of Funeral Service Licensee 22. Name and Address of Fapility Calvin L. Williams Funeral Service, P.A. P.O. Box 11651 Baltimore, Maryland. Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final e ptic **Physician** Shock disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner mmune ompromise Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed tastati Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) After the 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours efter death To the Funeral Director: completely filled in by the t 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ES0001

State Registrar

1

APR 2 5 2006

DR Joseph Ho 31. Date filed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print)

		i	1 - For State Registrar	State of M	arylan	-	artment of tificate of		and Me		giene	06	12746
6.00	Physici	an	1. Decedent's Name (First, Middle, Las	1)		Disease			3	2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al	William 4a. Facility Name (If not institution, give	atmat and aumbar		Dunn	4b. City, Town	or Location o	d Death	4	T	006 Inty of Death	12:40p M
	Examir	er	Future Care N.H			age		timore	n Death			NA	
	Funeral Director		5. Social Security Number 6. Se 214–40–7246			ast birthday) Yrs.	If Under 1 Yea Months Day		24 Hrs. 8 Min.	B. Date of Birt (Month, Da 4-29-		9. Birth Cou	place (State or Foreign ntry) N.C.
	and w		Usual Residence of Decedent 10a, State 10b, County		10c. City	y, Town or Lo	cation						10d. Inside City Limits
	Maryl -f sho	to	Md. NA			Balti	.more						Yes 2 No
	h the	irec	10e. Street and Number				10f. Zip Code				10g. Citizen	of What Cou	intry?
	23e c	raiD	1234 N. Elwood Av	е.				21213				USA	
920	be filed within 72 hours after death with the Maryland lat Hygiene. Id other than "natural", or Iteme 23e or 28e-f show event, the Medical Exertiral must be notified at	by Funeral Director	11, Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	,		Was Decedent of f Yes, specify Cu 1 ☐ Yes 2 ☑ N		gin? (Spec n, Puerto R	ify Yes or No- ican, etc.)		Race - Ameri Black, White ecity: B	
2-0	72 ho	eted	15. Decedent's Ed (Specify only highest grad			16a. Dece	dent's Usual Occ kind of work don	upation	t of working	2	16b. Kind o	f Business/Ir	ndustry
121	within ene. then "	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use reti	red)			Coxxx		te of Md. Instutional
22	filed v Hygie other t		12th grade 17. Father's Name (First, Middle, Last)			Cor	rection			First, Middle,			TISCUCTORIAL
Maryland 21215-0036	1 and 2 should Health and Mer tem 27 is marke	To Be	William		М.	Dur		Sa	rah	Ε.	F	Royste	
			19a. Informant's Name/Relationship (7 Sylvia Stewart	Sister			ng Address (Stre		et, S	pringd	ale, M	id. 20	0774
altimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		0	emetery, crei	sition (Name of matory or other p		Da 4 –21 –			on - City or T	
Balti	permit. Peges Depertment of Important: If it any injury or once.		21. Signature of Funeral Service Licens	W 10	-	22	Name and Add				altimo: E. No:		
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. CCV	ine.	20	er the mode of d	ying, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
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90,	be executed sicien and burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as									
8760,	physic physic the b	edicai		d				_				-	
.O. Box 6	death certif e attending ed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Feta	Ideath 3	Ectopic pregnar Other (specify)	ncy			23d.	Date of deliv Month	very Day Year
Δ.	law requires that the de es been signed by the a 2 should be detached i	ρ	Part II. Other significant conditions co	ontributing to death t	out not resi	ulting in the u	nderlying cause	given in Part I.			obacco use c		the cause of death?
Vital Records,	The ete h page	Completed							 .	24a. Was autop perfo 1 \(\text{Yes} \)			opsy findings available ompletion of cause of
/ita	ician: Th certificete rector, pag	Be (25. Was case referred to medical examiner?				10			Check only o			
of \	Physician: this certific ral director.	၉	1 ☐ Yes 2 DNo			ER/Outpatier	IL 3 DOA			e 5 Resid			rfy)
	After	lo	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time o Injury	W			3d. Describe I	low injury oc	curred	
Division	or At ofter of Direction by	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	on M 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office 28f. Location					Bf. Location (S City or Tox		umber or Rur	ral Route Number,	
	Hospita 4 hours Funera ely fille	edicai C	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best liner: On the basis of and manner st	of examina	wledge, deat tion and/or in	h occurred at the vestigation, in m	time, date an y opinion, dea	nd place, ar	nd due to the	cause(s) and date and plac	manner as	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1)				nse number			29d. Date sig		. Dey, Year)
			> Lugh.A	4.	/	M.D.	D4	740	5 5		4/18	8/00	5
Ü	21		30. Name and address of person who c	completed cause of	1 0	23a) (Type,	in to cont	st. E	Ball	ins	MI)21	20/
	Sta Regist		31. Date filed (Month, Day, Year) APR 2 5 20	32.4Regist	rar's Signa		sull's						

				k Indelible Ink. En	•		-	
	4	1 - State Registrar		epartment of Healt Certificate of Dea		Hygien Reg. N		12747
Physicia /Medic		Decedent's Name (First, Middle, Last) BARBARA ANN DAV	IS		2. Date of Month	1 12	7, 2006	3. Time of Death
Examin	er	4a. Facility Name (If not institution, give street and Sinal Hospital of B 5. Social Security Number 6. Sex	number) alfimore 7. Age (In yrs. last birt.	Be Himor	1:11		c. County of Deat	
Funeral Director	2	217-70-1352 1□ M XXIII Usual Residence of Decedent		rs. Months Days Hou	24/1	r) Co	RYLAND	
the Maryland 28a-f show	ctor	MD 10b. County N/A	10c. City, Town	or Location ALTIMORE CIT	Y			10d. Inside City Limits XXYes 2 □ No
uth with the 23a or 28 unt be not	al Director	10e. Street and Number 3601 OAKMONT AVENUE	E	10f. Zip Code 2121			Citizen of What Co	untry?
0 0 0	by Funeral	Armed	ecedent Ever in U.S. Forces? Som No Giver In Dates:	13. Was Decedent of Hispanic If Yes, specify Cuban, Me: 1 Yes 2 No Spe		r No-)	14. Race - Amer Black, White Specify: BL	
	Completed	15. Decedent's Education (Specify only highest grade complete	e (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)	most of working	16b.	Kind of Business/	industry
3 E T & E	Be	12TH 17. Father's Name (First, Middle, Last) ELBERT DAVIS			Hother's Name (First, Mi	ddle, Maide	OD SERV an Sumame)	ICE
nd 2 should alth and Me 27 ie mark r traumatic	2	19a. Informant's Name/Relationship (Type, Print) TIA DAVIS / DAUGHT!		Mailing Address (Street and No. 823 MAYFIELD	umber or Rural Route N	umber, City		
00	13,	20a. Method of Disposition XXBurial 2 Cremation 3 Removal fro 4 Donation 5 Other (Specify)	om State cemeter	Disposition (Name of y, crematory or other place) AWN CEMETERY		BA	Location - City or LTIMORE	CO., MD
permit. Pag Department Important: I any njury o		21. Signatur Inneral Service Licensee 23a. Mart1 Enter the disease, or complications th	Rowy	22. Name and Address of F	TY HEIGHT	S AV		OME 21207 IMORE, MD Approximate
Physician /Medical		shock, or heart failure. List only one cause of	to (or as a consequence of	cinoma	n as cardiac or respirati	my arrest,		Interval Between Onset and Death
Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	letabolic to (or as a consequence of	Acidosis				1 day
be executed sician and burial-transit	al Examiner	Cause (Disease or injury that initiated events c	to (or as a consequence of)f):				
The law requires that the death certificate be example to the best been signed by the attending physician bage 2 should be detached for use as the burial	Physician/Medical	in the past 12 months?	outcome of pregnancy ve birth 2 Fetal death egnant at time of death nknown	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of deli	very Day Year
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vicion: The law re scertificate has bee lirector, page 2 sho	Completed				1 1	Was an autopsy performed?	death?	topsy findings available completion of cause of
hysicial his certii	To Be			tpatient 3 DOA Other: 4	Place of Death (Check of Nursing Home 5		6 □Other (Spec	afy)
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director; After this certificate he completely filled in by the funeral director, page	Certification:	2 Accident investigation	Month, Day Year) II	ime of piury 28c. Injury at Work? M 1 Yes	2 🗆 No		jury occurred	(2-1-1)
s after of all Direct	CertIf	determined 288. P	lace of Injury - At home, fa uilding, etc. <i>(Specify)</i>	rm, street, factory, office		r Town, Sta		ral Route Number,
the Hospital or hin 24 hours afte the Funeral Dir npletely filled in	edical	(Check only 2 Medical Examiner: On the		death occurred at the time, dated or investigation, in my opinion,				
To th withir To th	Me	29b. Signature and title of certifier **Color Signature**	09)	29c. License num			pate signed (Monti	
3		30. Name and address of person was completed of	cause of death (Item 23a) (Type, Print) a i Hospital	of Baltir	nore		
	te		2. Registrar's Signature	(1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				

State Registrar

APR 2 5 2006 Menus 16

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician 208 pa 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Day, Year)

Dec. 28, 1919 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2004 Yrs 219-03-2643 86 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or items 23s or 28s-f show The Medical Examiner must be notified at 1 Yes 2 No Director Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 Bestgate Road #133 21401 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No ff Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify δ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education permit Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, If a Madic 900.8. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housewife 12 Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Thomas Woodfail Sarah Bloom 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Betty Brandenburg/ Daughter P.O.Box 584 Riva, Maryland 21140 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition April Date 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removal from State Glen Haven Mem. Park 2006 4 Donation 5 Other (Specify) Glen Burnie, MD 21. Signature of 22. Name and Address of Facility Singleton Funeral Home, P.A. MOILDO 1 Second Avenue SW GLen Burnie, MD 21061 Approximate Interval Between 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** SUBACUTE 130 TENIALL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner anding physicien and use as the burial-transit P.O. Box 68760 Physician/Medical ed by the attending a IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detact Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 1 🗌 Yes 4 TUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 20 No this certificate 2 No 1 Yes 1 Yes or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ၉ 2 ER/Outpatient 3□ DOA 1 🗌 Yes To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 1 Naturat 2 Accident Date of Injury (Month, Day Year) 28a. 28b. Time of 28c, Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending investigation 1 Tyes 2 TNo 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner, stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cegifier 31. Date filed (Month, Day, Year) State APR 25 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Bi Dutton 6:30 AM Jeorge 9 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban montgomery Hospital Bethesda If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 MM 2□ F 720-10-6474 87 Yrs. Massachusetts Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Montgomerv 1 Yes 2 No MD Bethesda 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5101 River Rd. Apt. 1418 20816 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give wwx Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Consulting Transportation Consultant 57 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Burwell Dutton, Sr. Sarah Cummings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5101 River Rd. Aft. 1418 Bethesda, MD 20816 Andrew Dutton/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-21-06 Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ropp Funeral + Cremation Services 1933 Grist Ave. Sitver Spring, MD 209 to mo1358 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CHF Due to (or as a consequence of): hypertension Pulmonary Sequentially list conditions, any, but ing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consecuence of Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Cther (specify) 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MiUnknown Hy pothy roldism 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy performed? 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 20a Cartifiar (Check only one) Contrying Physician: To the best of my knowledge, death becomed at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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7 ie marked other then "natural", or items 23a or 28a-f ehov traumatic event, <u>tre Medical Examinar must ke nytified al</u>

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Department of Health ar.
Important: If item 27 ie
eny injury or other trau Baltimore, Physician /Medical **Examiner** Examiner ં તે. within 24 hours after death certificate be executed burial-transit Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical ۵ cate has been sig , page 2 should b Be Completed this Medical Certification: within 24 hours after death.

To the Funeral Director: A completely filled in by the fu De062167 AKI MO 4/19/06 01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. AKhondi Asal 8600 Old Georgetown Rd. Bethesda, MD 20814 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar APR 2 5 2006 DHMH 17 Rev 1/2.01 DATE 4/19/06 DEATH ORIGINAL

06-02565 Marc Deleon

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

arc Deleon		State of Maryland / Department of Health and Mental Hy Certificate of Death		2006	12751
Physicia fedical Examin	ın/	Registrar 1. Recedent's Name (First, Middle,Last)	2. Date of Death	Dav Year	3 Time of Death 2237 hrs
		4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Sinai Hospital Baltimore		4c. County of Death	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min.	┥ .	(MM/DD/YYYY) 9. Birti	
<u> </u>		A4-44-3611 1 M 2 F 5 F Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10-6	1953 000	10d. Inside City Limits
Aaryland 28a-f show any 1 at once.	jo	MD Baltimore			1
ith the Maryland 23a or 28a-f sho notified at once	Director	3/30 Howard Park Avenue 2/207	109	g. Citizen of What Coun	try?
r death wi or itens must be	by Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year or Dates: 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Yes 2 No specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - Americ White, etc.	ck
1036 vithin 72 hours afte ene er than "natural", Medical Examiner	ompleted t	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Tyrs 16a. Decedent's Usual Occupation (Give kind of v during most of working ife, DO NOT use retired to the control of the control		16b. Kind of Business/Ir Televisi	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene Important: If item 27 is marked other than injury or other traumatic event, the Medical	o Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name Frederick DeLeon 19a. Informant's Name/Relationship (Type, Print.) 19b. Mailing Address (Street, and Number or F	ta As	aiden Surname)	7:2 (2-4-1)
, MD 2 and 2 shoul ealth and N em 27 is n raumatic	۲	Cassandra F. DeLeon/Wife 13130 Howard PK: No. 20a. Method of Disposition (Name of cemetery.		20c. Location - City or 1	21207
More Pages 1 nent of H ant: If i		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: Woodlawn Cemetry 4-	22-06	Woodlawr	mo
h h		21 S that is of Juneral S ince Licensee 2 In an Address of S this 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o	Randal	Istown, m	
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Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	O	3 Suicide 6 Could not be determined (Specify) Local street 29a. Certiffer 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and		reet and Number or Rur ate) 3100 BIK. He MD	
To the Howithin 24 h To the Fur	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated	it the time, date a	nd place, and due to the	cause(s)
	2	29b. Signature and title of certifier 29c. License number O.C.M.E.		29d Date signed (Mon April 18, 2006	tn, Day,Year)
		30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120	1		
St Regist	ate trar	31. Date filed (Month, Day, Year) APR 2 5 2006 32. Refistrar's Signature			
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	Physicia	an	Decedent's Name (First, Middle John	le, Last) S .		Fowlkes		2. Date of Dea		(ear 245 hoxs
	/Medic Examin	er	4a. Facility Name (If not institution)	General	Hospita	l Bali	or Location of Deat	City	4c. County of NA	
	Funeral Director		5. Social Security Number 217–54–3063	6. Sex 7. 1 1 1 2 □ F	Age (In yrš. last birtho	Months Days		8. Date of Birth (Month, Dey 12-14	4-50	9. Birthplace (State or Foreign Country) Md.
	Maryland f show	'n	Usual Residence of Decedent 10a. State 10b. County	, NA	10c. City, Town o	r Location				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
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936	after or Ite	by Funeral Director	727 Druid Par 11. Marital Status 1 □ Never Married 2 ☑ Mar 3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 Types 2	int Ever in U.S.	13. Was Decedent of If Yes, specify Cult	Hispanic Origin? (S ban, Mexican, Puer	pecify Yes or No- o Rican, etc.)		American Indian, White, etc. Black
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land 2	2 should be filed within n and Mental Hygiene. 18 marked othar then "raumatic event, It a Mar	To Be C	17. Father's Name (First, Middle, Wilbur	Last)	Fowlkes	5	18. Mother's Nar	ne (First, Middle,	Maiden Sumame,	
Maryland	permit. Pages I and 2 should be Department of Health and Menta Importent: if itam 27 Is marked any injury or other traumatic events.		19a. Informant's Name/Relations Annie Fowlkes	ship (Type, Print) Wife						tate, Zip Code) 21217 Baltimore, Md.
Baltimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		te cemetery,	isposition (Name of crematory or other pla	4-2	Date 8-06		ity or Town, State Mills, Md.
Baltin	permit. I Departm Importer any inju		21. Signature of Funeral Service		me	22. Name and Addr		Balt	imore, M E. North	d. 21202
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3760,	ate be executed nysician and ne burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequence of)					
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	w requires that the been signed by should be detact		Part II. Other significent condit ACQUIRED	ions contributing to deat		1	iven in Part I. IN DROM	The state of the s	_	oute to the cause of death?
Division of Vital Records,	sician: The law r certificate has be irector, page 2 sh	Completed by						24a. Whas a autop: perfor 1 ☐ Yes	med2 pri	ere autopsy findings available or to completion of cause of ath? Yes 2 No
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on of	ng Ph Iter th Ineral	tlon: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pendi	28a. Date of		ne of 28c. Injury	A		ow injury occurred	
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)	within 2 To the	Me	29b. Signature and title of certific	er A	1.0.	29c. Licer	nse number	7	PRIL	(Month, Day, Year)
4	10		30. Name and address of person	who completed cause	of death (Item 23a) (Ty	(pe, Print) TAW	STREE	7, BAZ	TIMORE	21201
	Sta Registi		31. Date filed (Month, Day, Year APR 2 5	2006 22. Reg	istrar's Signature	enti				

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	1. Decedent's Name (First, Middle, Last)				2. Date of Dea	ath		Time of Death
Physician - /Medical	Mar	ia D. Falli	n		APRIL	18 2	2006	1 pm
Examiner	4a Facility Name (If not institution, give street and it	number)		4b. City, Town, or L	ocation of Death	4c. County	of Death	
	Future Care			Balto		N/A		
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. last birtho	Months Davs		8. Date of Birt (Month, Day	h y, Year)		State or Foreign
Director	220-20-3636 Usual Residence of Decedent	79 Yrs	3.		3-15	- 1927	<u> </u>	/Id
aryland show	10a. State 10b. County	10c. City, Town o	or Location				10d. In	side City Limits
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ifer death with the Ma r Items 23a or 28e-1s incer must be notified Funeral Director	10e. Street and Number	A	10f. Zip Code			10g. Citizen of V	Vhat Country?	
th wi	3704 Park Heights Ave			.215		USA	A	
tems tems	Armed		 Was Decedent of if Yes, specify Cut 	Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	- 14. Raci Blac	e - American Ind ck, White, etc.	dian,
ors after all, or the practice of the practice	1 Never Married 2 Married 1 Yes 3 Widowed 4 Divorced Year or	3 2 No Give	1 ☐ Yes 2X No	Specify:		Specify	Black	
filed within 72 hours after death with the Maryland Hygiene. thar than "natural", or terms 23a or 28e-f show ant, the Medical Enaminer must be notified at e. Completed by Funeral Director	15. Decedent's Education		16b. Kind of Bu	usiness/Industry				
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y with	Elementary/Secondary (0-12) College 11th grade	(1-4or 5+) N/A N	urses Assi	tant		•		Hospita
be filed within 72 hor tall Hygiene. d other then "nature avent, the Medical I avent, the Medical I Be Completed	17. Father's Name (First, Middle, Last)	-		18. Mother's Nam	e (First, Middle,	Maiden Sumam	10)	
should b and Menta america umetica	Roland D. Fallin			Ida Cu	rry			
2 sho and is me	19a. Informant's Name/Relationship (Type, Print)	19b. M	lailing Address (Stree	t and Number or Rui	ral Route Numbe	er, City or Town,	State, Zip Code)
l and fealth m 27 har tr	Joy L. Patterson - Sis	ter 37	04 Park He isposition (Name of	ights Ave	nue Ba	lto, Md 20c. Location -		toto
Pages 1 nent of H int: If Ite iry or ot	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from the second sec	n State cemetery,	crematory or other pla					
t. Pa tmen tant: njury	4 Donation 5 Other (Specify)	Metro	Crematory		-23-06	Catonsv F/H Wes	ville, N	1d
permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene. Important: If tem 27 is marked other than any Injury or other traumetic avant, the Monce.	21. Signature of Funeral Service Licensee	0	22. Name and Addr	O Wabash		•		15
	Thethe A.	fines						
	23a. Part1. Enter the disease, or complications the shock, or he at failure. List only one cause or	each line.	enter the mode of dy	ing, such as cardiac	or respiratory ar	rest,	Inten	oximate val Between et and Death
Physician /Medical	Immediate Cause (Final	ſ						
Examiner	disease or condition resulting in death) a.	ypergen	nsequence of):				<u> </u>	
Je Je	00	Due to (or as a cor	A G C C	0-1	ade	*		
ate be executed hysician and the bunal-transit	Sequentially list conditions.	Due to (or as a cor	nsequence of):	Gr it	<i>A</i>			
be executed ician and bunal-transilal	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	e Dre ch	inu				į	
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uires the signer of the designer			U	24a. Was a	an autopsy	24b. Were au available	topsy findings	
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The law requir sate has been s page 2 should					1□ Y	es 20 No	1 □ Yes	28 No
an: T	25. Was case referred to medical			26. Place of Deat	th (Check only or	ne)		
hysicia nis cert I direct	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐	Inpatient 2□ER/Outpa	atient 3□ DOA Ot	ther: 42 Nursing Ho	ome 5□Resid	lence 6 🗆 Othe	er (Specify)	
ng Pt fter th uneral	27. Manner of Death 28a. Dat 1 ☑ Natural 5 ☐ Pending (Mo	e of Injury 28b. Tim onth, Day Year) Inju	ry Wo	ork?	28d. Describe h	ow injury occurr	ed	
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tal or Attending P is after death. al Director: After the following the funeration by the funeration:	determined 206. Fld	ce of Injury - At home, farm ding, etc. <i>(Specify)</i>	, street, factory, office	'	City or Tow	Street and Numb m, State)	er or Hural Hout	e ivumber,
pital ours e eral [filled	29a. Certifier 1 Certifying Physician: To the	ne hest of my knowledge d	eath occurred at the t	ime date and place	and due to the o	ause(s) and ma	nner as stated	
he Hospi in 24 hou he Funer pletely fill edical	(Check only 2 Medical Examiner: On the							ause(s)
To the Hospital or Attanding Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the Medical Certification: To Be Completed by Physician/Medic	29b. Signature and title of certifier	>	29c. Licen	se number	2	29d. Date signed	d (Month, Day,)	(ear)
	1,2,,,,	$\rightarrow \dots \wedge$	DE	5425	. 4	+1201	06	
2	30. Name and address of person who completed ca	use of death (Item 23a) (Ty	rpe, Print)	,		1 -1	2	1228
0,	Willie B. MYEN	BA 4130	Commo	nula	th AV	coopy	willed	us
State	31. Date filed (Month, Day, Year)	Registrar's Signature	andi				,	-
Registrar	APR 2 5 2006	CHE IN 19						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5:35 P Year **Physician** Month FRANTUM 2006 HOWARD 20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HAURE MEMORIAL HARFORD HUSPITAL dE GRACE HARFORD If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday)
Yrs. 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours 214-01-191 12 M 2 F MARYLAND Director 1611918 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f ehow other traumatic event, the Medical Examiner must be notified at BALTIMORE 1 Tes 2 No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 3032 ENYON AUE 236 21213 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or items 11. Marital Status 1 ■ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within i Department of Health and Mental Hygiene. Important: If Item 27 ie marked other then "n any injury or other traumatic event BETHLEHEM Elementary/Secondary (0-12) College (1-4or 5+) MILLWRIGHT 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be EDNA FRANTUM JAMUEL 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2111 BUEL FALLSTON, MD VANDERWAGEN Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State APRIL mcemetery, crematory or other place) 1 ■Burial 2 Cremation 3 Removal from State ISACTMORE, MD MARK * 4 ☐ Donation 5 ☐ Other (Specify) 24, 2006 MEMOCIAL 21. Signature of Faneral Service Licenses 8800 22. Name and Address of Facility HARFORD RD. PARKUILLE, MD 21234 FUNERAL CHADEC Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine that initiated events been signed by the attending physician and should be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): 68760 Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 🛛 № 3 ☐ Probably 4 ☐Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No me 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Dipatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 9 1 Tyes 211No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; After To the Hospital or Attending Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Direct 4 Homicide 29a. Certifier t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

rrantum, Howard

Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue

32. Registrar's Signature

31. Date filed (Month, Day, Year) APR 2 5 2008

(Check only one)

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend, item 5 per fb 9855 5-2-06 vt.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year **Physician** 4:35 AM 04 FRAZIER 20 2006 MICHAEL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death Examiner BALTIMORE HUSPITAL JAMARITAN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) (4/23/42 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 07 **Funeral** 1₽M 2□F Days 220-76-2970 3 Yrs. Director NEST VIRGINIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show The Medical Examiner must be rivilified at 1 ☐ Yes 2 ☐ No Director MD BALTIMORE BALTIMONE 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code RD. 238 3210 MOUGHBY 21234 USA Funeral . Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other than any injury or other traumatic event, Ira Magang Jones. Elementary/Secondary (0-12) ENGINEER ENGINEERING JACOBS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MARY MICHAEL JANE AVID 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RD. BACTIMORE, WIFE 3210 MO 21254 FRAZIFR -20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition APRIL cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State BERKELEY SARINGS WV 4 ☐ Donation 5 ☐ Other (Specify) MT. ZION CEMETERY 22, 2006 9800 HARFORD LO 21. Signature of Fuperal Service Licensee 22. Name and Address of Facility PARKUILE, MO 21274 CHAPEC FUNERAL 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Severe AUDUSUS **Physician** merabouc /Medical Due to (or as a consequence of): Examiner Septic Shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine -transit Encenhaio Due to (or as a consequence of): attending physicien a for use as the burial-Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Dav 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ ausease 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? llucourtous 2. No 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director. 25. Was case referred o medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Gerthying Physician: To the best of my knowledge, that included at the time, date and close, and due to the cause(s) and meaning as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4/24/06 nels RES-000 MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Samoulan houritar, 5601, Lock vaven NIHARIKA DIXIT, hood 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Bisso & Aprile Registrar

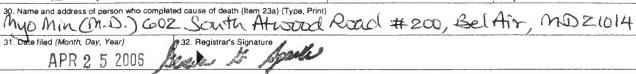
DHMH 17 Rev 1/2001

		1 - For State Registrar	State of M	aryland / I		irtment of F tificate of		Mental Hy	/gieñe Reg. No.	000	12.7	156
Physic	ian	1. Decedent's Name (First, Middle, Las				3-44		2. Date of Do Month	Day		ar	of Death
/Med Exam		Geneva E. Fit: 4a. Facility Name (If not institution, give		1		4b. City, Town, o	r Location of Deal	APRIL		County of E	6	M
LAdin		Lorien Nursin	g Home			Colum				Howa	rd	
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Iryland 21215-0036 should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other then "natural", or items 23a or 28a-1 ehow mails event, the Medical Evantinar marks and item to the routiled at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 Tes 2 Tes If Yes, Give Year or Dates:	?	21	Vas Decedent of H i Yes, specify Cuba	Ispanic Origin? (San, Mexican, Puer Specify:	to Rican, etc.)	0-		American Indian Vhite, etc. White	
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I HECONTS, P.O. BOX 6 The law requires that the death certific the has been signed by the attending to age 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 most/s? 1 □ Yes 2 ☑ No 9 □ Unknown		of pregnancy 2 □ Fetal death It time of death		Ectopic pregnancy Other (specify)			:	23d. Date of Month	delivery Day	Year
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DIVISION Of VITAI To the Hospital or Attending Physician: within 24 hours after death. To the Funerei Director: After this certifics completely filled in by the funeral director;	Medicai (29a. Certifying Ph (Check only one) Certifying Ph 2 Medical Exam	ysician: To the best niner: On the basis of and manner st	of my knowledg of examination a lated.	je, death nd/or inv	occurred at the tir vestigation, in my o	ne, date and plac pinion, death occ	e, and due to the urred at the time	cause(s) , date and	and manne I place, and	er as stated. due to the caus	e(s)
To t To t	Σ	29b. Signature and title of certifier)			29c. Licens	e number		29d. Dat	te signed (N	fonth, Day, Yea	r)
		30. Name and address of person who	completed cause of	death (Item 23a)	(Type	DO (05315	0	AP	RIL	2220	2006
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Regis DHMH 17 Rev 1	à-	(Check only 2 Medical Example) 29b. Signature and title of certifier 30. Name and address of person who Shawmak 31. Date filed (Month, Day, Year)-	006	w B.	160							
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1-	For State Registrar

			= State Registrar			Certi	ficate of	Death	I	Reg. No.	100	3 Euro P 100 F
ı	Dhysisi		1. Decedent's Name (First, Middle, Las						2. Date of Dea		a a Year	3. Time of Death
	Physici /Medio		HARRIE	Γ		FOL	US		APRIL	22,	2006 ^{ear}	12:48 A M
-	Examin		4a. Facility Name (If not institution, give 1476 LANDIS CIR			4	b. City, Town,	or Location of Death BEL A				ARFORD
	Funeral Director		5. Social Security Number 6. Security Number 213-26-8973	ex 7. Age □M 2√ F	_		If Under 1 Year Months Days		8. Date of Birt APR. 29	, 1929	9. Birth Cou	place (State or Foreign ntry) MD
	D N		Usual Residence of Decedent 10a. State 10b. County		10c City	. Town or Loca	tion					10d. Inside City Limits
	faryli sho	៦	MD BALTII	MODE	,			ΡΔΝΠΔ	LLSTOWN			1 ☐ Yes 2 🔀 No
	28a-1	Director	10e. Street and Number	TORL			10f. Zip Code	INTINUA	LLSTOWN	10a Citize	en of What Cou	
	Sa or		3710 VALLEY HIL	DRIVE		:		21133				USA
	ms 2	Funerai	11. Marital Status	12. Was Decedent 8	Ever in U.S	S. 13. Wa	s Decedent of	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No	- 14	Race - Ameri	
1215-0036	within 72 hours after death with the Maryland ene. Than "natural", or Items 23e or 28e-f show he Medical Examiner must be notified at	b	1 ☐ Never Married 2 ☐ Married 3 🛱 Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 (A) N If Yes, Give Year or Dates:	No		Yes 2.1XX No		rican, etc.)		Black, White,	WHITE
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2		ខ	17. Father's Name (First, Middle, Last)			HUME	MAKER	18. Mother's Nam	o /First Middle		N HOME	0.1
Maryland 21	ould be filed Mental Hyg arked other atic event,	To Be	BENJAMIN			SMIT		ANNA				Cohn COHEN
	and 2 shi salth and n 27 is m		BRIAN FOLUS / S			1476	LANDIS	S CIRCLE -	BEL AI	R, MD	21015	
Baltimore,	Pages 1 an nent of Heal int: If itsm 2 iry or other		20a. Method of Disposition 1 🛱 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		ce	ace of Disposit emetery, crema H TFILO	tory or other pla	ace)	4/2006		ation - City or T	
Balti	permit. Pag Department Important: i any injury o		21. Signature of Funeral Service Licen	see			Name and Addr	ess of Facility S	OL LEVI ROAD -			
			23a. Party. Enter the disease, or com- shock, or heart failure. List only	cations that caused	the death	. Do not enter	the mode of dy	ing, such as cardiac	or respiratory ai	rest,		Approximate Interval Between
,	Physician		Immediate Cause (Final disease or condition	m				Breast				Onset and Death
J.	/Medical		resulting in death)	Due to (or as			-					
	Examiner		Sequentially list conditions,	b								
1	sit	lue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ience ol):						
Lo	and I-tran	Examiner	that initiated events resulting in death) Last	cDue to (or as	a consequ	ence of):						
68760,	certificate be executed iding physician and ise as the burial-transit	//Medical E	l	, d								
o X	certifica nding pl use as t	/Mec	IF FEMALE:	23c. If yes, outcome	of prepara	nev				-	1.50	
	taw requires that the death of seen signed by the attendance of should be detached for up	Physician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3□E	ctopic pregnand other (specify)	су		23	d. Date of deliv Month	ery Day Year
٦.	that i		Part II. Other significant conditions c	ontributing to death b	ut not resu	Iting in the und	erlying cause g	iven in Part I.	23e. Did to	obacco use	contribute to t	the cause of death?
Sp	uires sign ld be	d by							101	res 2 🗹	No 3 □ Proi	bably 4 □Unknown
Ö	w require been sig should b	Completed							24a. Was	an	24b. Were auto	opsy lindings available
Vital Records,	The la	Ĕ							autop	rmed?	prior to co death?	ompletion of cause of
<u>ra</u>	in: T		25. Was case relerred to medical					26. Place of Deat	1 ☐ Yes		1 🗆 Yes	2 □ No
>	nysician: The law nis certificate hes I director, page 2 s	To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	ent 2 🗆 8	ER/Outpatient	3□ DOA O	ther: 4 Nursing Ho			Other (SpSG	n's Residence
Division of	ding PI h. After tf funeral		27. Manner of Death 1 Hatural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day		28b. Time of Injury	28c. Inju		28d. Describe I			<i>"</i>
		Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	ury - At ho c. (Specify	me, farm, stree	t, lactory, office	•	281. Location (S City or Tox		Number or Run	al Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical C		ysician: To the best of niner: On the basis of and manner sta	f examinat							
	within 2 within 2 To the	Me	29b. Signature and title of certifier	4				nse number			signed (Month,	
	- 5 - 0		· My		n -	D .	1	145390		Apr	1122	200C

State Registrar 31. Date filed (Month, Day, Year) APR 2 5 2006



Physician Allie /Medical Examiner 5. Social Security Number **Funeral** Director 230-82-2977 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County rai', or iteme 23a or 28a-f ehow Examiner aust be notified at Md Charles Director 10e. Street and Number by Funeral 11. Marital Status 1 ☐ Never Married 2 ☐ Married "natural", or 31☑ Widowed 4 □ Divorced Completed the Medical is marked other than Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Be Ernest ပ္ permit. Pages 1 and 2: Department of Health ar Important: if Item 27 is any injury or other traconce. Allie 20a. Method of Disposition 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses

Physician /Medical Examiner Examine burial-transit The law requires that the death certificate be executed P.O. Box 68760. Physician/Medical nding physics use as the use as jo been signed by the should be detached Completed by Division of Vital Records. page 2 or Attending Physician: director Be To After thi funeral (Certification: death. the within 24 hours after deat To the Funeral Director: completely filled in by the filled in by Hospital To the

1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Gardner APRIL 19 2006 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death CIVISTA MEDICAL CENTER **CHARLES** LAPLATA If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours Min. **XX**M 2□ F 54 Yrs. Aug. 27, 1951 Virginia 10c. City, Town or Location 10d. Inside City Limits Laplata 1 ☐Yes 2X No 10f. Zip Code 10g. Citizen of What Country? 301 Goose Creek Drive 20646 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2√2 No Specify: Specify: Black 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Farm Farmer 18. Mother's Name (First, Middle, Maiden Surname) Gardner Viola Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5827 Fisher Road#101 Temple Hills, Md20748 L. Gardner-Son 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Antioch Bapt. Church 4/26/06 Champlain, DBurial 2 Cremation 3 Removal from State 22. Name and Address of Facility best Chinn Funeral Service 2605 S.Shirlington Rd.Arl.Va.22206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final arluse disease or condition resulting in death) Due to (or as a consequence of): Acute Glomerulonephritis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1 ☐ Yes 2 3 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 → No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1- Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00 2006. 0 D-52289 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NALIN MATHUR MD 10 ST. PATRICKS DR. STE 404 WALDORF, AD 20603 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 23b per doc g854 4-25-06 vt.
State of Maryland / Department of Health and Mental Hygiene

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death **Physician** 9 2:00 am 2006 /Medical 4b. City, Town, or Location of Death. 4c. County of Death Examiner Year If Under 24 Hrs. yrs, last birthday, If Under 1 Year 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Director Usual Residence of Decedent 10a. State 10b. County City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show the Medical Exercitor must be cottlied at 1 os 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3600 by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementa (3-contary (0-12) is marked other then College (1-4or 5+) nTinance 18. Mother's Name (First, Middle, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 Is marked oth eny injury or other traumatic event anger, Be ၉ b. Mailing Address (Street and Number or Rural R Method of Disposition

| Burial 2 | Cremation 3 | Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Serv ce dicensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Winknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 🗆 No 2 2 No 1 Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 1 Inpatient 1 ☐ Yes 2 ₺No 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signalure and title of certifier

Registrar

4

State

31. Date filed (Mario R

Registrar's Signa

30. Name and address of person who completed cause of death (Item 23a)

06-02583 Denise Gilliam

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		I- For State Registrar	a.c ca. , .a	Certific	ate of Deat	h	Re	eg No.	12/00
Physicia Medical Exami	in/	1. Decedent's Name (First, Midd		lliam	,		2. Date of Deat Month April 16, 2	h Day Year	3. Time of Death 1610 hrs
		4a. Facility Name (if not institution 2300 Terra Firma Roa	on, give street and number)			Town, or Location of Dea		4c. County of Death	
Funeral Director		5. Social Security Number 213 · 60 · 6924	6. Sex 7. Ag	e (In yrs. last bir	thday) If Und Month Yrs.	ler 1 Year If Under 24Hns Days Hours M	lin	Foreig	hplace (State or in untry)
nd show any <u>ce.</u>	_	Usual Residence of Decedent 10a State 10b. County N	IA	10c. City, Town	or Location	ione			10d Inside City Limits 1 Yes 2 No
th the Maryland 23a or 28a-f show notifie <u>d at once.</u>	Director	10e. Street and Number 2300 Terra	Firma Ro	<u> </u>	10f. Zip			og Citizen of What Cour	ntry?
ter death with	Funeral	11. Marital Status 1 Never Married 2 M	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Decede If Yes, speci	ent of Hispanic Origin? (fy Cuban, Mexican, Pue No specify:	Specify Yes or No- to Rican, etc.)	White, etc.	can Indian, Black,
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f shomatic event, the Medical Examiner must be notified at once	Completed by	15. Decedent's Education (Spe Elementary/Secondary (0-12)	or Dates: ecify only highest grade con		Decedent's Usual	Occupation (Give kind orking life. DO NOT use r		16b. Kind of Business/I	ndustry
imore, MD 21215-0036 Pages I and 2 should be filed within 72 nent of Health and Mental Hygiene nant: If item 27 is marked other than or other traumatic event, the Medical	Be Com	17. Father's Name (First, Middle Albert NUS			Oursu		me (First, Middle, N e Folv		
- p = e e l	10	19a. Informant's Name/Relations USA 5. NUSU 20a Method of Disposition	ship (Type, Print)	nter 2	2332 R	(Street and Number of	r Rural Route Num	Balto. MD	21217
Baltimore, M permit Pages I and 2 Department of Health Important: If item 2 injury or other traum		1 Burial 2 Cremation 4 Donation 5 Other S 21 Signature of Funeral Service	pecify:			hel o	Date + 24.06	Baltin	ione MID
		23a. Part I. Enter the disease, oi	wett I.	I the death Don	Compas 3000	es ion Funer E. Baltimor	al Sewice re Street	Balto. Mp :	21224 Approximate Interval
Physician /Medical 		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line.	theroscleroti			o i respiratory and	ast, shook, of fleat	Between Onset and Death
	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	equence of):					4
executed an and al - transit	Exa	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consi	equence of):					
	/Medical	UNPENDED IF FEMALE:	AMENDED 23c. If yes, outcor	me of pregnancy	Santa			23d. Date of delivery	
lox 68 leath certifi e attending for use as t	Physician/	23b. Was decedent pregnant in t past 12 months? 1 Yes 2 No 9 Un	4 Pregnant at	t time of death	Fetal death Other (Spe		nancy	Month D	day Year
cords, P.O. Blaw requires that the data been signed by the should be detached	2	Part II. Other significant condi	ions contributing to deat	h but not resultin	ng in the underlying	g cause given in Part I.		bacco use contribute to	
Division of Vital Records, rate or Attending Physician: The law requirers after death at Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed			 -			24a Was a autop. perfor	sy prior to c med? death?	topsy findings available ompletion of cause of
n of Vital Rec ling Physician: The After this certificate funeral director, page	BeC	25. Was case referred to medica examiner?				26.Place of Death (Ched			
of Vit ing Physic After this c	밁	1 ✓ Yes 2 No						Residence 6 🗸 Other	Scene
ion of ttending I feath tor: After		27. Manner of Death 1 Natural 5 Pen 2 Accident Inve	28a. Date of Inju (Month, Day,Y ding estigation	ury 28b. Year)	Time of Injury	28c. Injury at Work? 1 Yes 2 No	28d. Describe h	now injury occurred	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Certification:	4 Homicide dete	Id not be 28e Place of In (Specify)	njury - At home, f	arm, street, factory	, office building, etc.	28f, Location (S or Town, S	Street and Number or Ruitate)	ral Route Number, City
To the Hos within 24 h	Medical		hysician: To the best of maminer: On the basis of exa and manner stated						
	ž	29b. Signature and title of certification		ws	29	c. License number		29d. Date signed (Mor April 17, 2006	nth, Day,Year)
\		30. Name and address of persor Theodore King MD.	Assistant Medical E	Examiner	111 Penn Stre	eet, Baltimore, MD	21201	1.	
Si Regis	ate rar	31. Date filed (Month, Day, Year) APR 2	5 2006 32. Registra	ar's Signatur	Appelle				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 19,_ 8:40 P M April Cornelia Gomeringer 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Rosedale Manor Care- Rossville Blvd If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) February 4, 1925 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F 217-12-0243 81 Yrs Maryland Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow r than "natural", or items 23a or 28a-f ehov the Medical Examinar must be notified at Dundalk 1 ☐ Yes 2 No Directo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7163 Eastbrooke Avenue 21222 USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Evarinms Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No þ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 12 years years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen May Sinn Vernon Koontz Reynolds 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7163 Eastbrooke Avenue, Dundalk, Maryland 21222 Joe Gomeringer son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date April 24, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Garrison Forest VA Cem 2006 Owings Mill, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Roint Road, Dundalk, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 80 S **Physician** /Medical Examiner monta Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ettending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ned by the etter 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown ate has been signed by page 2 should be detact Part II. D**ther significent conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably → Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 25 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MA who completed cause of death (Item 23a) (Type, Print) Z4842 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene () ()

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	Physici		 Decedent's Name (First, Middle, L Richard Wayne Gr 	-						2. Date of De Month April		2006 Yea	3. Time of Death 2:00 PM	
	/Medio Examir	- 4	4a. Facility Name (If not institution, gi 9578 Canterbury				4b. City, Town		ition of Dear		4c.	County of De	ath	
	Funeral Director		5. Social Security Number 6. 132-38-0206	Sex 7. Age 1 Mg 2 F	56	st birthday) Yrs.	If Under 1 Year Months Day		nder 24 Hrs urs Min		rth av, Year) 1949	9. B	irthplace (State or Fore Country)	
	tryland thow	_	Usual Residence of Decedent 10a. State 10b. County			Town or Lo	cation						10d. Inside City Lim	
	he Ma 28a-f	ecto	MD Howard		Lau	rel							1 Tes 2	
	23a or 2	Funeral Director	9578 Canterbury	Riding			10f. Zip Code 20723				USA	izen of What	Country?	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hyglene. Important: If Item 27 is marked other then "natural", or Iteme 23a or 28a-f ehow any follury or other traumatic event, the Midlical Examinate roual be notified at ance.	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Privorced	12. Was Decedent E Armed Forces?, 1 Yes 2 N If Yes, Give Year or Dates:			Was Decedent of f Yes, specify Co 1 ☐ Yes 2 1 1 1 2 1 1 1 1 1		ic Origin? (S exican, Puer ecrty:	Specify Yes or No to Rican, etc.)	D-	14. Race - Ar Black, Wi Specify: Wh		
Maryland 21215-0036	within 72 ho liene. r then "natur ine Madical	Completed	15. Decedent's (Specify only highest g		+)	16a. Deced (Give life.	dent's Usual Occ kind of work doi DO NOT use ret	cupation ne during ired)	most of wa	rking	ss/industry ucation			
land 2	should be filed and Mental Hygie and Mental Hygie amarked other umatic event, II	To Be C	17. Father's Name (First, Middle, Las Gilbert Grabisch	•					Mother's Na	me (First, Middle te Selig		Sumame)	-	
	and 2 shouselth and N n 27 is mai		19a. Informant's Name/Relationship Jeanne Greene/Sis							ural Route Numb				
Baltimore,	Pages 1 and the control of Hee nut: If I tem		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		Cer	metery, crer	sition (Name of natory or other p ke Crema	•	Y	Apr 24 2006			or Town, State , Maryland	
Balti	permit. Departir Importa any Inju		es more, M	aryland										
	tificate be executed Medical By physician and as the burial-transit	Medical Examiner	shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a Due to (or as a d.	a conseque	ence of):	of U	Kno	bun	Perma	8º9		Interval Between Onset and Death 3 Moudelles	
.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 9 □ Unknown	2 Fetal o	death 3	Ectopic pregnal			1		23d. Date of o	lelivery Day Year	
rds, P.	quires that n signed b uld be deta	þ	Part II. Other significant conditions	contributing to death bu	it not resul	ting in the u	nderlying cause	given in I	Part I.			Approximate Interval Between Onset and Death 3 Mount III Services of Month Day Year Month Day Year 2 12 No 3 Probably 4 Unknown 24b. Were autopsy findings availating prior to completion of cause death?		
I Records,	ding Phyeician: The law require h. After this certificate has been si funeral director, page 2 should I	Completed								24a. Was auto perfe 1 Yes		prior to	o completion of cause of	
Vital	Physician: this certificanal director,	Be	25. Was case referred to medical examiner?	Hospital:					Place of De	ath (Check only				
o	Physic rethis oral direction): To	1 ☐ Yes 2 (No 27. Manner of Death	28a. Date of Injury (Month, Day		R/Outpatier 28b. Time of	3000		☐ Nursing I	dome 5 Res			pecify)	
Division	or Attending after death. Director: Afte in by the fune	Certification:	1 Natural 5 Pending 2 Accident investigate 3 Suicide 6 Could not 4 Homicide determine	be 280 Blace of Injur	ıry - At hon	Injury ne, farm, str	M 1	Yes	2 🗆 No		Street an	nd Number or	Rural Route Number,	
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical Co	29a. Certifier (Check only one)	Physician: To the best of aminer: On the basis of and manner state	examination	rledge, deatl on and/or in	n occurred at the vestigation, in m	time, da y opinion	ite and plac i, death occ	e, and due to the urred at the time,	cause(s)	and manner d place, and d	as stated. ue to the cause(s)	
		Me	29b. Signature and title of certifier Michillas / Rou	heleks mi	>		29c. Lice						nth, Day, Year)	
	- Sta	ite	30. Name and address of person when Nicholas Routine 31. Date filed (Month, Day, Year)	completed cause of de la la la la la la la la la la la la la	Li H	23a) (Type, Le PAT 11re	Print) Uxent	Dry	Colu	ubis Vi	nd z	21044		

State Registrar

		For State Registrar	State of Marylar		artment of H		-	giene (06	12763
		1. Decedent's Name (First, Middle, Las	t)				2. Date of De	ath Day	V	3. Time of Death
Physici		Concetta Mary Gra	v				Month	2	2006	12:45 PM
/Medi Examir		4a. Eacility Name (If not institution, give			4b. City, Town, or	Location of Dea	th	4c. Cou	inty of Death	
		Franklin Squar	e Hospital		KOSI	edale		K	altir	nore
Funeral		5. Social Security Number 6. So	D		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th y, Year)	9. Birthp Cour	lace (State or Foreign
Director		214-22-4658	1 78 THE TENT	Yrs.			09/08	3/1927	MD	
and *		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or L	ocation				1	0d. Inside City Limits
Maryl feho	ö	MD Baltimo	TO						İ	1 ☐ Yes 2 ☐ No
178 288	Je C	10e. Street and Number	16		10f. Zip Code			10g. Citizen	of What Cour	ntry?
3a or	Funeral Director	5301 Kenwood Aven	11e		21206			USA		
death ms 2	ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Specify Yes or No	14.	Race - Americ Black, White,	
or Its	F	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 ☑No If Yes, Give		1 ☐ Yes 2 No	Specify:	rto riibari, oto.,		ecify:	etc.
Sours Sours	d by	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:						Whit	
nati	Completed	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of we	orking	Own H	of Business/In	dustry
withir then	Ę.	Elementary/Secondary (0-12)	College (1-4or 5+)		maker	7		Own	Ome	
filed Hygie nt,	ပိ	12 17. Father's Name (First, Middle, Last)		110me	marer	18. Mother's Na	ame (First, Middle	, Maiden Sun	name)	
Id! yidilid Z.I.Z.13-0030 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "naturel", or Items 23s or 28e-1 show sumatic event, the Medical Exeminat mast be notified at	To B	Eugenio Lepore				Adeline	Bancale	•		
shoul nd M mar	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ng Address (Street	and Number or F	Rural Route Numb	er, City or To	wn, State, Zip	Code)
ING allth a 27 te r treu		Carson Gray/Son		5301	Kenwood	Avenue	Baltimor	e, MD	21206	
of He is		20a. Method of Disposition	20b.	Place of Disp cemetery, cre	osition (Name of matory or other place	(e)	Date Apr 24	20c. Location	on - City or To	own, State
Page Page Int: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification)	Hemoval Irom State		ke Cremat			Belts	ville,	Maryland
DESILITIOTE, INCLYIGITION 2.12.13-0050 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23s or 28s-1 show any injury or other treumatic event, the Medical Exemplrat must be notified at able.		21. Signature of Funeral Service Licer	500		2. Name and Addres		ral Altern	natives		
D SOFFS		dy da Sue	Killer Maly	43	8717 Green	Pastures	Drive I	Baltimo		yland 21286
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea one cause on each line.	ith. Do not er	ter the mode of dyin	ig, such as cardia	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition	a teritor	itts						
/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):	15.					
Examine.	<u>_</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	CULT	773					
be isi	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to for as a conse	querice or).						
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oor ou, ificate be ex g physicien as the buria			d							
GOX OX leath certificat attending phy for use as th	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr		□Estania programa			23d.	Date of delive	ery
death death d for	tcla	in the past 12 months?	1 Live birth 2 ☐ Fel 4 ☐ Pregnant at time of 9 ☐ Unknown		□Ectopic pregnancy □ Other (s <i>pecify)</i>				Month	Day Year
that the death	Physician/Med	9 Unknown								
v 8 5 8	by	Part II. Other significant conditions of	ontributing to death but not re	sulting in the	1	. 4.				he cause of death?
ecord law require as been si	ted	Kespii addi 9 Tu	mure por	rui u	1.0	ar ilisea		Yes 2□N		oably 4 □Unknown
law ras by a 2 sh	Completed by	MI, BM, COP	D, Atheros	lerot	it carcil	vascul	auto		4b. Were auto prior to co death?	ppsy findings available impletion of cause of
or VICAI KEC hysician: The law his certificete has b I director, page 2 s	S	disease					1 ☐ Yes	2 No	1 Yes	2̂₩ No
OT VITAL Physician: ' this certifice ral director, p	Be	25. Was case referred to medical examiner?	Hospital: 🍇		Oth	er	eath (Check only			
0 2 - 6	2	1 Yes 2 No	28a. Date of Injury (Month, Day Year)	28b. Time	INT 3LI DOA	4 U Nursing	Home 5 ☐ Resi			y)
VISION OI Attending Phr r death. ector: After thi by the funeral	tion	1 Natural 5 Pending 2 Accident investigatio		Injury		rk? Yes 2∐No				
DIVISION or Attending effer death. Director: Affe	ifica	3 Suicide 6 Could not b	e 28e. Place of Injury - At building, etc. (Spec	home, farm, s	treet, factory, office			(Street and Newn, State)	umber or Rur	al Route Number,
	Certification:	4 Hornicide	building, etc. (Spec	ary)			Only of 10	, 0.0.0)		
Hospital 24 hours e e Funerel i		(Check only 2 Medical Exam	nysician: To the best of my kr miner: On the basis of examin	nowledge, dea nation and/or i	th occurred at the time	me, date and pla ppinion, death oc	ce, and due to the curred at the time,	cause(s) and date and pla	d manner as s ice, and due t	stated. o the cause(s)
To the Hospital or within 24 hours effe To the Funeral Dir completely filled in	Medicai	one) 29b. Signature end title of certifier	and manner stated.		29c. Licens	se number		29d. Date si	gned (Month,	Day, Year)
F ₹ 5 8		hut I	Company			846		4.	-21-1	5/-
h		30. Name and address of person who	completed cause of death (Its	em 23a) (Type		0 / 0			-1 (,0
9	ĺ	Dr. Martin T.	Sheridan 9	000 Fr	anklin S	anare)	Drive	Bait	b. Mi	21237
S	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	9 .	1)	
Regis	trar	APR 2 5 2006	Regular St.	nature (
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DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	aryland /		nt of Health a	and Mental Hy	400	16 12764
	Physici /Medio		1. Decedent's Name (First, Mic	Micha	el	Ga	ntert	2. Date of D. Monfh	19 20	Year 3. Time of Death
<i>></i>	Examir Funeral Director		4a. Facility Name (If not instituted to the Social Security Number $412-78-4262$	6. Sex 7. Ag	e (In yrs. last b	(BAI	y, Town, or Location of LTIMORE or 1 Year If Under 3 Source Hours	24 Hrs. 8. Date of Bi	4c. County of	Birthplace (State or Foreign Country)
	D.		Usual Residence of Decedent 10a. State 10b. Cour	ıty	10c. City, Tov	wn or Location		APRIL	28,194	10d, Inside City Limits
	death with the Maryland oms 23a or 28a-f ehow	Director	TN SHE	TR I	MEMPI		Zip Code		10g. Citizen of W	1 Yes 2 □ No /hat Country?
		Funeral D	11. Marital Status	LBY DRIVE 12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Dec	38116 edent of Hispanic Orig pecify Cuban, Mexican	gin? (Specify Yes or N , Puerto Rican, etc.)	USA o- 14. Race Black	- American Indian,
2-0036	72 hours after "naturel", or ite	þ		ent's Education		a. Decedent's Us	No Specify:		Specify:	
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ryland	d 2 should be fi th and Mental H ?7 is marked out traumatic aver	To Be	17. Father's Name (First, Middle THOMAS GANT	ERŤ	10	h Madia Adda	BE	r's Name (First, Middle ERNICE HE	CKMAN	
re, ma	1 an Heal em 2		STEPHANIE G		ster 5	564 CHI	RISTYBROC	r or Rural Route Numb OK SOUTHA Date	VEN, MIS	SISSIPPI 38671 City or Town, State
airimo	mit. Peges pertment of portant: If It y Injury or o		1 XBurial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other 21. Signature of Funeral Servi		CAL		EMETERY 4	/25/2006 HENRY W.		S, TENNESSEE S & SONS CO.
מ	9		23a. Part1. Enter the disease, shock, or heart failure. L	or complications that caused ist only one cause on each lin	the death. Do			C ROAD MO		Approximate Interval Between
	Physician /Medical Examiner		fmmediate Cause (Final disease or condition resulting in death)	Due to (or as	aconsequence	Vascar of:	lar Acc	ident		Onset and Death 2 days
3/60,	sate be executed hysicien and the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Aw	a consequence	19-26	il /	zukem,	2	18 months
O. Box 6	ding p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, oufcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal deat	h 3 ⊟Ectopic 5 ⊟ Other (23d. Date Mont	of defivery th Day Year
cords, r	law requires that the death as been signed by the etter 2 should be detached for u	è	Part II. Other significant cond	tions contributing to death b	ut not resulting	in the underlying	cause given in Part I.		,	bute to the cause of death? 3 ☐ Probably 4 ☐Unknown
Ĕ	sician: The law re certificate has be rector, page 2 sho	Completed	Pany	topenia				24a. Was auto perfe 1 🗆 Yes	psy promed? de	ere autopsy findings available for to completion of cause of eath?
on of vital	Phys this ral di	lon; To Be	25. Was case referred to mediexaminer? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pen	Hospitaf: 1 Inpatie 28a. Date of Inju (Month, Da)	ry 28b.	utpatient 3 [] [Time of Injury	OOA Other: 4 Nur 28c. Injury af Work?	1		
DIVISION	al or Attending after death. I Director: After d in by the fune	Certification:	3 ☐ Suicide 6 ☐ Cou	d not be mined 28e. Place of fnj building, et	ury - Af home, f. c. (Specify)	arm, street, factor	1 □ Yes 2 □ N ory, office	28f. Location ((Street and Number wn, State)	r or Rural Route Number,
	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical	one)	ring Physician: To the best all Examiner: On the basis of and manner sta	examination at	nd/or investigation	on, in my opinion, deat	place, and due to the h occurred at the time,	cause(s) and man date and place, an	ner as stated. nd due to the cause(s)
	To the within 2.	Σ	29b. Signature and file of certi	M. C) ,	2	9c. License number RES – DC	treet Ba	April 19	(Month, Day, Year) 2006
6	Sta	to	30. Name and address of personal street of the street of t	fante mo	eath (Item 23a) 6 0 0 ar's Signatûre	(Type, Print)	Wolfe S	treet Ba	Himore	mo 21287
	Registr		APR 2	5 2006	S. S.S.	A STATE OF THE PARTY OF THE PAR	772			

Physician
/Medical
Examiner

MINIA

b City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Dak-Crest Vi Has If Under 1 Year If Under 24 Hrs. Months Days Hours Min. August 6, 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** 1**XX**M 2□ F 212-05-2664 Yrs. 91 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10h County 7 is marked other than "natural", or items 23a or 28e-f show traumatic evant, the Marked Examinating in the Confident Mary land Baltimore Parkville Director 10e. Street and Number 10f. Zip Code 8820 Walther Boulevard Apt. 4524 21234 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours atter Hygiene. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 No <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic evant, If a Neulic one. Elementary/Secondary (0-12) College (1-4or 5+) 12 District Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carle Graeser Matilda Schmuck 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pearl K. Graeser /Wife 8820 Walther Blvd. Apt. 4524 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Hilltop Service Corp. 4/24/06 5 ☐ Other (Specify) 4 Donation Leonard J. Ruck Inc. 5305 Hartord Road Baltimore Maryland 21. Signature of Funeral Service Licensee Christina L. Hilton J hustera 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Lluna Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy tor in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) Yes 2 No should be detached the 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by sair ment 24a. Was an certificate has page 2 autopsy performed 1 Yes 20 Physician: tuneral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residence Certification: To 2 ER/Outpatient 3 DOA After this Manne of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of or Attending Injury 5 Pending 1 ☐ Yes 2 □ No investigation death 2 Accident the Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide within 24 hours a completely filled 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

tiraeser

4c. County of Death
But nove Birthplace (State or Foreign Country)
 Maryland 10d. Inside City Limits 1 Yes 2XXNo 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Business Machines Parkville, MD 21234 20c. Location - City or Town, State Towson, Maryland Approximate Interval Between Onset and Death 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 No 6 ☐Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

3. Time of Death

11:00 PM

Year

91

State Registrar

31. Date filed (Month, Day, Year)

APR 2 5 2006

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32. Registrar's Signature

8832 Walther Blud

BENJAMIN

			For State Registrar	State of Maryland		nent of Health			line U	06	12766
			Decedent's Name (First, Middle, Last	t)				. Date of Death			3. Time of Death
	nysici: Medic		Benjanin	Griffin				Month 1 PRIL	Day 23	Year 2006	12:55 AM
	xamin		4a. Facility Name (If not institution, give			City, Town, or Location			4c. Cou	nty of Death	
			ST. AGNES Hos 5. Social Security Number 6. S	PITAL 7. Age (In yrs. le		3ALTIMOR		Date of Birth		NAT	lace (State or Foreigi
	neral ector			DM 20 F		nths Days Hours	Min.	Date of Birth (Month, Day,	1935	- 94	indee (State of Foreign
yland	14		10a. State 10b. County	10c. City	, Town or Location	7				1	0d. Inside Oity Limits
e Mar	Liffed	ctor	Maryland NI	H	Bat	timore					1 Yes 2 No
th with th	at be no	Funeral Director	702 Cooks (ane Apt.	101	f. Zip Code	29	10	g. Citizen	of What Cour USA	ntry?
1215-0036 within 72 hours after death with the Maryland ene.	any njury or other traumatic event, its Medical Examinational Lancilled at 0000.	۾	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Fes 2 ☐ No If Yes, Give Year or Dates:	If Yes	Decedent of Hispanic Co, specify Cuban, Mexico	an, Puerto Ric	y Yes or No- can, etc.)	E	Race - Americ Black, White, city: Black	
21215-0036 d within 72 hours at gione.	lical i	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)		Usual Occupation of work done during mo	ost of working	1		Business/Inc	dustry
diffic	& Max	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO N	OT use retired) Driver	ost or morning		Mar	fland	Transit
filed v	ti H	ပိ	17. Father's Name (First, Middle, Last)				her's Name (/	First, Middle, M	laiden Sur	Admin	istration
Maryland d 2 should be file th and Mental Hy	lc • v	To Be	Charles Gril	Cin			ora J	Toh 150	h		
ary shou	E .		19a. Informant's Name/Relationship (1	ype, Print)	19b. Mailing Ad	dress (Street and Numi		Route Number,	City or To	vn, State, Zip	Code) 2/2/1
and 2	or tra		Dors L. Onff	n-wife _	2123	Chelsea	Ten	ace b	atto		laryland
Baltimore, benut. Pages 1 a Department of Hea	or of	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	ace of Disposition metery, cremator	(Name of or other place)	Dat		•	n - City r To	
Itim F. Pa rtmen	n lury		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of F neral Service ★ Cen		unsville	Vet. Cemi	7-28	-06	-YOWI	wille	, Marylan
Balt permit. Depart	S D		21. Signature of the land of the land	Wa -	25. Nal	Falls : k	larke	rture	ult	tome, P	A. 1 212
			23a. Part1. Enter the disease, or companies shock, or heart failure. List only	dications that caused the death.	. Do not enter the	mode of dying, such a	is cardiac or r	espiratory arre	st, re	Mary	Approximate
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c 68 artifica	as a	Med	IF FEMALE:			·					
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P.O. BOX nat the death cerd by the attending	be detached for use as	by Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of de 9☐ Unknown	atn 5∐Otne	er (specify)					
s that	e deta	y P	Part II. Other significant conditions of	ontributing to death but not resul	Iting in the underly	ring cause given in Part	11.	23e. Did toba	acco use co	ontribute to th	e cause of death?
ords oquire en sig	d bluc		ANEMIA					1 🗆 Yes	2 □ No	3 Prob	ably 4 Unknown
law ra	ge 2 should b	Completed						24a. Was an autopsy	24	b. Were autop	osy findings available apletion of cause of
: The	director, page	S						pertorm 1 ☐ Yes 2	ed?	death?	
VITA siclen certifi	rector	Be	25. Was case referred to medical examiner?	Hospital:		Othor		Check only one			
Phys Of	era di	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury	P/Outpatient 3[28b. Time of	28c. Injury at Work?		5 Resident			")
nding ath:	e funeral	atioi	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury M		-				
DIVISION Of VITAI RECORDS, P.O. el or Attending Physicien: The law requires that the safter death of the physicians and safter that the in Director: Alier this certificate has been signed by the	completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, street, fa	actory, office	28f	Location (Stre City or Town,	et and Nu State)	nber or Rura	Route Number,
To the Hospitel o within 24 hours af To the Funeral D	letely fille	edicai (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	vsician: To the best of my know iner: On the basis of examinati and manner stated.	vledge, death occu on and/or investig	urred at the time, date a ation, in my opinion, de	and place, and eath occurred	I due to the cau at the time, dat	ise(s) and e and plac	manner as st. e, and due to	ated. the cause(s)
To th within To th	comp	Me	29b. Signature and title of certifier	MAR		29c. License number		29	d. Date sig	ned (Month, I	Day, Year)
01) X V	- MD		P19512	-	A	PRIL	23,	2006
11			30. Name and address of person who o			S. CATON	ALLE	BAIT	I N O C	E 110	21226
	Sta	0	31. Date filed (Month, Day, Year)	HIVELNATHAN 32. Registrar's Signatu			AVE,	DALI	MOK	E MI	1 21117
R	egistr:	_		32. Registrar's Signatu	1 Speed	V					
DHMH 17 F	Rev 1/20	01	APR 2 5 2	JUO I AMERICAN STREET	1						

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Mar		partment of Fertificate of			ene g. No.	12767		
	Physici /Medio		Decedent's Name (First, Middle, Las MURIEL	it)	G0	LOMBEK		2. Date of Death Month APRIL	Day Year 19, 2006	3. Time of Death		
ı	Examir		4a. Facility Name (If not institution, give Saint Joseph	street and number) Medical C	Center 4b. City, Town, or Location of Death				4c. County of Death Balt	imore		
	Funeral Director		5. Social Security Number 6. Social Security Number 1	7. Age (i	n <i>yrs. last birthda</i> 81 Yrs.	// If Under 1 Year Months Days	If Under 24 Hrs Hours Min		9. Birthg	place (State or Foreign		
	ylend		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or	Location			1	10d. Inside City Limits		
	Ba-f st	ctor	MD BALT	IMORE	BAL	TIMORE				1 ☐ Yes 2 🂢 No		
	death with the Marylend ms 23a or 28a-f show rmette radiiled at	D re	10e. Street and Number 16 OLD COURT ROA	\ # / 112		10f. Zip Code	21208	10	g. Citizen of What Cour	ntry? USA		
36	be filed within 72 hours after death with the Manylen tal Hyglene. d other than "natural", or itams 23a or 28a-f show avent, the Medical Examinar must be recitled at	by Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give	or in U.S. 13	. Was Decedent of H If Yes, specify Cub.		Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White, Specify:	can Indian,		
9	2 hour	ted b	3 🕅 Widowed 4 □ Divorced 15. Decedent's Ed	Year or Dates:	16a. Dec	edent's Usual Occup	ation	16	6b. Kind of Business/In	dustry		
Maryland 21215-0036	within 72 hours after ene. than "natural", or its he Medical Examina	Completed	(Specify only highest gra	College (1-4or 5+)		(Give kind of work done during most of work life. DO NOT use retired) HOMEMAKER			OWN HOME	•		
מפר	be filed tal Hygid d other avent,	Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, Ma				
<u>yla</u>		To	MORRIS		FEU			E UNKNOWN				
Baltimore, Mar	d2 ha 7 tr	i i	19a. Informant's Name/Relationship (7					ural Route Number, (ALTIMORE,	City or Town, State, Zip MD 21208	Code)		
	C T S S		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	20b. Place of Disposer cemetery, cr	oosition (Name of ematory or other place TIFERETH	(a)	Date 20	ROSEDALE,			
Balt	permit. Page Depertment of Important: If any Injury or once.		21. Significant Funeral Service Lice	nuser		22. Name and Addre	5		ON & BROS.,			
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one-cause on each line. Immediate Cause (Final Properties									
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		CREATIC	CARCIN	OMA		Onset and Death		
	Examiner			Due to (or as a c	onsequence of):							
/	ed sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence of):							
6876U, 🗴	ificate be executed g physicien end as the burial-transit	edical Examiner	that initiated events resulting in death) Last	C. Due to (or as a cod.	onsequence of):							
O. BOX 68	death certifi e attending id for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of a 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	□Ectopic pregnancy			23d. Date of delive Month	ory Day Year		
coras, r	requires that the een signed by th nould be detache		Part II. Other significant conditions or	entributing to death but n	ot resulting in the	underlying cause giv	en in Part I.	23e. Did toba	cco use contribute to the	ne cause of death?		
Ů	The la	Completed						24a. Was an autopsy performe	prior to con death?	psy findings available inpletion of cause of		
VITA	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital: , , , , , , , , , , , , , , , , , , ,		ont all DOA Oth		ath (Check only one)				
lon of	After Lune	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	2 ER/Outpatie 28b. Time Injury	of 28c. Injur Wor	4 U Nursing r	10me 5 Residence 28d. Describe how	ce 6 Other (Specify injury occurred	y)		
UNISION	To the Hospital or Attend within 24 hours efter death To the Funeral Director: completely filled in by the f	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (5	- At home, farm, s Specify)	treet, factory, office		28f. Location (Stre City or Town,	et and Number or Rura State)	l Route Number,		
	he Hospil in 24 hour he Funeri pietely filli	edical	29a. Certifier (Check only one) 1 Certifying Phyone) 2 Medical Example 1	rsician: To the best of miner: On the basis of ex and manner stated	amination and/or i	th occurred at the tin	ne, date and place pinion, death occu	e, and due to the cau urred at the time, date	ise(s) and manner as st e and place, and due to	ated. the cause(s)		
	To t To 1	Σ	29b. Signature and title of certifier	m	D.	29c. Licens		290	d. Date signed (Month,	Day, Year)		
	\cap		30. Name and address of person who c			D240	025		4/14/06			
	7		EDUARDO P. LAY	UG. M. D.			ER DRIV	E TOWSON	MARYLANI	21204		
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 5 2006	32. Registrar's	Signature	(L)		Service Service, B. V.				

06-02701 Albert Earl Heiges Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

CIL L	u		1- For State Registrar	otate of Maryland		ificate of		anu	IVICILIAI	, 0	Reg No	2006	12768
	Physici I Exami		Decedent's Name (First, Michael Control of the				_			2. Date of De Month April 21,		Year	3. Time of Death 0842 hrs
ruica	LAGIII	IIIGI	Albert Farl F 4a. Facility Name (If not institut	leiges tion, give street and number)		4	b. City, Tow	n, or Lo	cation of Dea			lc. County of Dear	
			3500 Woodbine Roa	d			Woodbi	ne			- 1	Howard	
	uneral		5. Social Security Number		e (In yrs. las	st birthday)	If Under 1	Year Days	If Under 24H Hours M	Irs. 8. Date of t	Birth(MN	M/DD/YYYY) 9 8 Fore	rthplace (State or
	irector		204-14-9321	1XM 2 F	30	Yrs.	Months	Days	Hours		24,	1925 °	ountry) PA
	any		Usual Residence of Decedent 10a. State 10b. Count	у	10c. City, T	own or Location	on		-				10d Inside City Limits
7	show:	'n	MD Howa	rd	Woo	dbine							1 Yes 2 X No
	28a-f	Director	10e Street and Number		, ,,,,,,	, doing	10f. Zip Co	ode			10g. Ci	tizen of What Cou	untry?
-	13a or 28a-f show any notified at once.	ıl Diı	3500 Woodbin				217	_				ted Stat	es
	or items	Funeral	11. Marital Status 1 Never Married 2	12. Was Decedent Armed Forces?			Decedent of s, specify C	of Hispa Cuban, N	nic Origin? (1 exican, Pue	Specify Yes or I to Rican, etc.)	N o-	14. Race - Ame White, etc.	rican Indian, 8lack,
	II', or		3 Widowed 4 D	1 X Yes 2	No	1	Yes 2 X	No :	specify:			Specify: Wh	ite
	"natural",	ed by	15. Decedent's Education (Sp			16a Decedent			(Give kind o		16b.	Kind of 8usiness	
36	han "	Completed	Elementary/Secondary (0-12	2) College (1-4 or 9	5+)					om ou)		1	
00-	ed within 7. tygiene other than the Medical	Com	17. Father's Name (First, Midd			Electi	ricai			me (First, Middle		estingho n Surname)	use
21215-0036	permit, rages 1 and 2 snotud oe nieds within 72 nous after ucent with the manyanu pepartment of Health and Menla Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the <u>Medical, Examiner must be notified at once.</u>	Be	Albert Earl H	leiges, Sr.				M	abel (Groves			
0.2	and Me	7										City or Town, Stat	e, Zıp Code)
Σ,	and a		Dorothy Heige 20a. Method of Disposition	s (wife)	20b. Pl	3500 Tace of Disposit	lon (Name	ine of ceme	Rd Wo	odbine,		21797 . Location - City o	r Town, State
nore	ages intoff nt: If i		1 X 8urial 2 Cremati		aic	ematory or othe		74 (om /	/26/2006	. _	Mi	11- 10
Baltimore, MD	partme portar ury or		4 Donation 5 Other 21. Signature of Funeral Service	ce Licensee		22. Na	ame and Ad	dress of	Facility			wings Mi	
			23a. Part I. Enter the disease,	lellha		121	rier-(2 W. (Juee O <u>ld</u>	n rune Libert	eral Hom	ie ai Vinf	nd Crema ield. MD	tory, P.A 21784
	ysician Nedical		failure. List only one caus	se on each line.			e mode of d	lying, su	ch as cardiad	of respiratory a	irrest, sh	nock, or heart	8etween Onset and
Ęx.	aminer		Immediate Cause (Final disease or condition resulting in death) a. Contact Gunshot Wound to Head Due to (or as a consequence of):								Death		
		L.	Sequentially list conditions,	b									
		nine	if any, leading to immediate cause. Enter Underlying Caus (Disease or injury that initiated		equence of):								
	ed nsit	Examiner	events resulting in death) Las	t Due to (or as a conse	equence of):								
	icate be executed physician and the burial - transit		UNPENDED	damended		,			-				+
760,	care be physici he buri	Medical	IF FEMALE:	23c. If yes, outcor	me of pregna	ancy					23	3d. Date of deliver	y
	certification of the second of	cian/	23b. Was decedent pregnant in past 12 months?		time of dear	H	al death		Ectopic preg	nancy		Month	Day Year
Вох 68	ine taw requires that the death certificate has been signed by the attending page 2 should be detached for use as it.	Physician	1 Yes 2 No 9 L	Inknown 9 Unknown		5 Oth	er (Specify)					
P.O.	rnar rne red by 1 detache	by P	Part II. Other significant cond	ditions contributing to death	h but not res	sulting in the ur	nderlying ca	use give	en in Part I				the cause of death?
S.	w requires that as been signed b should be deta									- 1 Y			bably 4 Unknown
Sor	has be	Completed								aut	opsy formed?	prior to	utopsy findings available completion of cause of
Re	ificate rr, page		25. Was case referred to medi	22			26	Diago of	Death (Ch.	1 ✔ Yes		No 1 🗸 Y	es 2 No
/ital	ling rhysician: The law After this certificate has funeral director, page 2 s	o Be	examiner?	Hospital:	ent 2 E	R/Outpatient		O+	Death (Chec	sing Home 5	Resid	lence 6 🗸 Othe	er: Scene
of	ng rn After tl uneral	-	27. Manner of Death	28a. Date of Inju	(near)	28b. Time of In	jury 28c	. Injury	at Work?		e how in	jury occurred	
ion	death. ctor: y the f	atio		vestigation Apr 21, 2006	3355	FOUND: 0834 hrs	1		2 V No	Subject sh	iot sei		
Division of Vital Records,	alor A safter Il Dire ed in b	Certification:	. de	ould not be termined 28e. Place of In		ne, farm, street	i, factory, of	fice buil	ding, etc.	or Town	State)		ural Route Number, City
	Hospit 4 hour Funcra ely fill		29a. Certifier	Physician: To the best of m		e. death occurr	ed at the tin	ne date	and place a	1		Road, Woodi	
	to the Hospital of Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director.	edical		kaminer: On the basis of exa and manner stated									
	- 5 - 5	×	29b. Signature and title of cert		11	_		icense r			29d.	Date signed (Mo	onth, Day, Year)
			\	1 M. 1	1	_		D.C.M.	E.		Ар	ril 22, 2006	
19	XI		30. Name and address of personal Jack Titus MD. Do	who completed cause of c eputy Chief Medical E		23a) 111 Penj	n Street	Baltin	nore. MD	21201			
١,		tate		2 5 2006 ^{32. Redistra}			gold)	- 21011					
	Regie		APK	Z D LUUU AADM	BAR D	200							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#31, per IVR, 9854, 4/25/06 TT Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 21, **Physician** 2006 4:00P M /Medical Kurt J. Hager 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Johns Hopkins
5. Social Security Number Bayview 6. Sex 7 Baltimore
Under 1 Year | If Under 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **X**□ M 2□ F 217-76-2722 45 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 ☐ Yes 2 ☑ No Dunda1k 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 744 Aldworth Road 21222 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 D No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 Ho Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LeRoy J. Hager Mary Ann Simmons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karl Hager - Brother 744 Aldworth Rd., Dundalk, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State St. Stanislaus 4-25-06 *4 □ Donation 5 □ Other (Specify) Baltimore, MD 22. Name and Address of Facility Bradley-Ashton Funeral Home, 21. Signatura of Funeral Service Licenses PA, 2134 Willow Spring Rd., 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Heratite ~10 yu Due to (or as a consequence of): 1 kou Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death Month 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 1 No 2 3 No 1 Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Certification: To 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00023650 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HF. Herlong, mo 4640 tosten ave.

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be filed within tent of Health and Mental Hygiene. int: If Item 27 is marked other than '

Injury or other

permit. Page Department of Important: If any Injury or once.

Physician /Medical

Examiner

and the burial-tran

signed by the attending physician

this certificate has

death.

after death

within 24 hours a To the Funeral C

completely filled in by the

use as

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

32. Registrar's Signature

▶APR 2 5 2006

Jack Higley 06-02667 crn

-02667	Please		iack indelible ink. Ensure	•	275 and 275 and 275 and 474 area
1	For	State of Maryland	d / Department of Health and	Mental Hygier	EUU6 12//U
	1 - State Registrar		Certificate of Death	Reg. N	ło.
	1. Decedent's Name (First, Middle, Last			2. Date of Death Month	3. Time of Death
Physiciar /Medica			HIGLEY	APRIL	19 2006 19:52 "
Examine	A. E. Berther Manne //d and leasterston and an	street and number)	4b. City, Town, or Location of Deat		4c. County of Death
	The Johns Hor	Icines Hosp	etal Baltimore	- City	N/A
Funeral	5. Social Security Number 6.5e			8. Date of Birth	9. Birthplace (State or Foreign Country)
Director	236-26-3196	2M 2□F 82	Yrs.	3-5-10	124 Michigan
2	Usual Residence of Decedent	10.00	, Town or Location		10d. Inside City Limits
trylar show	10a. State 10b. County		, Town or Location		1 Tyes 2 THO
e Ma	E MD Balt	more Pr	arkville		
5 or 2	10e. Street and Number		10f. Zip Code	10g. (Citizen of What Country?
filer death with the Maryland ritems 23a or 28a-f show liner must be redified at	2505 Maribar	rough Dr.	21234		USH
dea	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
5-0036 72 hours after natural; or ite		1 Yes 2 □ No If Yes, Give	1 Ves 20 No Specific		Specify: (1) hite
21215-0036 so within 72 hours all giand than "natural; or the Madical Examil."	3 ☐ Widowed 4 ☐ Divorced	Year or Dates: WWI			
72 h	15. Decedent's Edi (Specify only highest grade Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)	nking 16b.	Kind of Business/Industry
within then the Me	Elementary/Secondary (0-12)	College (1-4or 5+)	100 - 1		selfemployed
d 21	3 14		Mechanic	me (First, Middle, Maide	
De da da da da da da da da da da da da da	17. Father's Name (First, Middle, Last)	C 11:-1	18. Mother's Na	me (First, Middle, Maidl	an Sumame)
Sould Meridian Meridi	Benjamir	Similar	riay	CARET	1171000
Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Marylan its and Mental Hygiene. Z'le marked other than "natural", or items 23a or 28a-f show treumatic event, the Medical Examinar must be incutified at	19a Informant's N e/Relationship (T)	po, Printi wite	19b. Mailing Address (Street and Number or R	ural Houte Number, City	or Town, State, Zip Code) 2 1334
_ < = ~ .	MIVEY FOL I.	17191E	ace of Disposition (Name of	196 1	aria le mo
Des 1 t of H if ite or oth	20a. Method of Disposition 1 Derial 2 Ocremation 3 D	11 0	emetery, crematory or other place)	12°22 20c.	Location - City or Town, State
E P P P P P P P P P P P P P P P P P P P	□ Donation 5 □ Other (Specify,		anstuneral Itome ai	20P H	rest Hill MD
Balti permit. Departm Importe eny inju	21. Fight ture of Pineral Service Licens	88	22. Name and Address of Filty	ns Funera	al Chaple!
m go = 2 g	CAR YEAR	1	8300 Harford R	a Ranko	11emp 21234
	23a. Part1. Enter the disease, or comb shock, or heart failure. List only	lications that caused the death ne cause on each line.	. Do not enter the mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between
Physician	Immediate Cause (Final disease or condition		FRACTURES	,	Onset and Death
/Medical	resulting in death)	Due to (or as a consequ			1.3
Examiner	Conventially list conditions	MOTOR VI	EHICLE COLUSION	\mathcal{A}	13 HOURS
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	rence of):	11/2	
outeo Cuteo	that initiated events	c	<u> </u>	There were	ER
'60, che executed sicien and burial-transit		Due to (or as a consequ	rence of):	MEDICAL EXAMINE	
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Geath certificete e attending phys d for use as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		GERTIFICA		
Box eath cert attending for use	23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal	ncy		23d. Date of delivery
dea death	in the past 12 months?	4 Pregnant at time of de 9 Unknown	eath 5 Other (specify)		Month Day Year
P.O. hat the did by the detached	9 Unknown				140000
- 50 .	Part II. Other significant conditions co	ntributing to death but not resu	Ilting in the underlying cause given in Part I.		o use contribute to the cause of death?
of Vital Records, Physician: The law requires t this cartificate has been signs ratidirector, page 2 should be				1 🗆 Yes	2 No 3 Probably 4 □Unknown
BCC law re as be 2 sho	COD			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Re it the it to be age ?	E			performed 1 ☐ Yes 2 🖭	death?
Vital F	25. Was case referred to medical		26. Place of De	ath (Check only one)	
of Vital Re Physician: The ribis certificate he ral director, page	examiner? Yes 2 No	Hospital: 1 Inpatient 2 🗆	ER/Outpatient 3 DOA Other: 4 Nursing	Home 5 ☐ Residence	6 ☐Other (Specify)
ng Ph ter th		28a. Date of Injury (Month, Day Year)	28b. Time of lnjury at Work?	28d. Describe how in	iver of a minivan
Vision Attending If death. ector: After by the fune	1 Natural 5 Pending 2 Accident investigation		5:03 A M 1□Yes 2□No		ided with a truck.
Division or Attending after death. Director: After S in by the fune	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, factory, office	28f. Location (Street	and Number or Rural Route Number, ate) 6800 Block of Harfo
S after of Digital Dig	27. Manner of Death 1	banding, ore: (opean)	Roadway	Road, Baltin	more, Maryland
ospit hour uner ly fills			wledge, death occurred at the time, date and plac	e, and due to the cause	(s) and manner as stated.
Division or To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	one)	and manner stated.	tion and/or investigation, in my opinion, death occ		
withi Comp	29b. Signature and title of certifier	70 -	29c. License number	29d. t	Date signed (Month, Day, Year)
	1 / Mu	CK, MD	RES-000	AP	RIL 19 2006
4	30. Name and address of person who o		23a) (Type, Print)		
	BENJAMIN MANDE	- 600 NORTH	WILLE GREET BAND	MORE, MD	21287-9166
Stat	e 31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture Angelia	,	
Registra	APR 2 5 1	LUUD A BREAK .	12. Wallet		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

Reginald Keith H		State of Maryland / Department of H Per State Certificate of D Registrar			200	6 12772
Physicia Medical Examir	n/	1. Decedent's Name (First, Middle,Last) REGINALD KEKH HUNT		2. Date of Deat Month April 16, 2	Day Year	3. Time of Death 2030 hrs
**			City, Town, or Location of Death Security	1	4c. County of E Baltimore	
Funeral			f Under 1 Year If Under 24Hrs	_		Birthplace (State or oreign
Director	ļ	227 · 90 · 8846 1 K M 2 F 49 Yrs.	Months Days Hours Min	07.06.		Country) VA
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d Inside City Limits
&	5	MD GLEN BURNI				1 Yes 2 No
within 72 hours after death with the Maryland giene. her than "natural", or items 23a or 28a-f show.	Director	609 MINNERVA ROAD	Of. Zip Code	10	og. Citizen of What	Country?
with th		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was D	ecedent of Hispanic Origin? (Sp		14. Race - A	American Indian, Black,
r death or iten	Funeral	1 Yes 2 No	specify Cuban, Mexican, Puerto	Rican, etc.)	White, e	BLACK
urs afte	ā	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's t	es 2 K No specify: Usual Occupation (Give kind of v		Specify: 16b. Kind of Busin	
6 172 ho an "na ical Ex	lete	Elementary/Secondary (0-12) College (1-4 or 5+)	of working life. DO NOT use reti	ired)	00.0000	
-003 d within	Completed	12 TH GRADE 4 YRS MAN	AGER 18. Mother's Name	e (First, Middle, N		ing firm
₹ = ± 5 3	Be	JAME ROBERT HUNT, SR.	MILDRED			
MD 212. d2 should be lith and Menta m 27 is marke	٩			. DANVI		24540
re, N s 1 and of Health of Titem	1	2Ca. Method of Disposition 1	n (Name of cemetery,	Date	20c. Location - Ci	
Baltimore, permit Pages I an Department of Hee Important: If ite		4 Donation 5 Other Specify. FLORAL HILL M	IEMORIAL 04.	23.06	DANVILLE	
Bal permii Depar Impo		21 Clignature of Funeral Service Licensee 22 Nam VAUG 5151	BALTO, NATL PI	FUNIERA PA	I SERVICE	1229
Physician /Medical		23a. Part I Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.				Approximate Interval Between Onset and
Txaminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):				Death
		Sequentially list conditions, b				
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Cleases or injury that milicit ad				
executed an and al - transit		events resulting in death) Last Due to (or as a consequence of): d				
50, e be executed ysician and burial - transit	edical	UNPENDED AMENDED				
1876(tificate ing phy as the b		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal	death 3 Ectopic pregna	ancy	23d Date of de Month	livery Day Year
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Funeral Director: After this certificate has been signed by the attending physicitely filled in by the funeral director, page 2 should be detached for use as the burilled in by the funeral director, page 2 should be detached for use as the buril	Physician/M		(Specify)		9	
O. B at the d d by the		Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I	23e. Did to	bacco use contribu	te to the cause of death?
S, P. uires th	ed by					Probably 4 Unknown
cord law req has bee	ompleted			24a. Was a autop perfor	sy prio	re autopsy findings available or to completion of cause of ath?
Rec The ifficate or, page	ပ	25. Was case referred to medical	26 Place of Death (Check	1 🗸 Yes		Yes 2 No
Vital ysiciar this cert directo	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3	_ loubes _		Residence 6	Other: Scene
n of Vi ding Physi After this funeral dir	no T:Uo	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 1 Network 284. A 200 Page 200 Pag	ry 28c. Injury at Work? 1 Yes 2 ✔ No	28d. Describe to Driver in MV	now injury occurred A	
ivision or Attene after death Director:	ertification:	2 Accident Investigation 28e. Place of Injury - At home, farm, street, f		28f. Location (S	Street and Number	or Rural Route Number, City
Division Septral or Attent hours after death meral Director: y filled in by the	Certif	3 Suicide 6 Could not be determined (Specify) Major Road / Highway		or Town, S I-70 Westbo	tate) ound ?, Securit	y, Md.
To the Hospital within 24 hours	Medical C	29a Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred one) Physician: To the best of my knowledge, death occurred one one one of the basis of examination and/or investigation and manner stated	at the time, date and place, and in my opinion, death occurred	d due to the caus at the time, date	e(s) and manner as and place, and due	s started to the cause(s)
E ₹ 3 8	Me	29b. Signature and title of certifier	29c. License number			(Month, Day, Year)
15		Carolitallain	O.C.M.E.		April 17, 200	b
17		 Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Str 	eet, Baltimore, MD 2120	01		
St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 2 5 2006	all .			

			For State Registrar	State of Maryland / Department of Health and Certificate of Death	d Mental Hygier	2000 12/10
	Physicia	ın	1. Decedent's Name (First, Middle, Last)	HAIRSTON	2. Date of Death Month	Day Year 3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give		path -	4c. County of Death
			Howard Couns 5. Social Security Number 6. Ses	y Seneral Columbia 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H	Irs. 8. Date of Birth	9. Birthplace (State or Foreign
l.	Funeral Director		225-76-3916	M 20 F 5/ Yrs. Months Days Hours Mi	in. 9-21-195	54 Country LA
	yland		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location		10d. Inside City Limits
	the Mar 28a-f el	Director	MD Howar	d Columbia	100	1 ☐ Yes 2 🐪
	th with 23a or	ai Dir	5640 Gulfstred	1)		USA
	Items Inst. The	uner		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.
5-0036	72 hours after death with the Maryland natural; or Items 23a or 28a-f ehow acal Examiner must be notified at	Completed by Funeral	3 Widowed 4 Divorced	If Yes, Give 1 1 Yes 20 No Specify: Year or Dates:		Specify: Black
15-(nin 72 h n "natu Madica	piete	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		working 16b.	. Kind of Business/Industry
12121	filed within Hygiene. other then "		17. Eather's Name (First, Middle, Last)	ityrs Customer Vervice Mex	Oresentative Name (First, Middle, Maid	Retail
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show appriants or items and the traumatic event, the Macical Examinat must be notified at once.	To Be	John Vallie	Hairston Willi		way
Man	od 2 sho ith and P 27 le ma r trauma		19a. Informant's Name/Relationship (Ty Helen Lawrence	19b. Mailing Auress (Sweet and Number of		or Town State, Zip Code)
_	es 1 an of Heal fitem 2 r other		20a. Method of Disposition 1 28 Burial 2 Cremation 3 F	20b. Place of Disposition (Name of condition) translation State		Location · City or Town, State
Baltimore,	permit. Pag Department Important: I eny injury o		4 Donation 5 Other (Specify) 21. Signature of Fune al Service Licens	Memorial Gardens 4	124/06 G	rdl Services
Ba	permit Departr Importa eny inji		Vaugna C.	Treese 8728 Liberty Rd	. Randall	stown, MD 21133
			shock, or heart failure. List only o	ications that caused the death. Do not enter the mode of dying, such as card	diac or respiratory arrest,	Approximate Interval Between Onset and Death
1	/Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	%	1 HES.
	Examiner	ě	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):		
V	xecuted and il-transit	Examiner		s		
760,	ate be executed obysician and the burial-transit	ical Ex	resulting in death) Last	Due to (or as a consequence of):		
(887	eath certificate be exettending physician for use as the buria	Medic	IF FEMALE:			
Box	death certifica e ettending ph id for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1		23d. Date of delivery Month Day Year
P.O.	t the by th ache	Physi	9 Unknown	9□ Unknown	an Didustra	co use contribute to the cause of death?
	S		HYPEL TELSION	ntributing to death but not resulting in the underlying cause given in Part I.		2 No 3 Probably 4 □Unknown
ecol	aw ds b	Completed by	,		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
al B	₹ 5 g	е Соп		20 80	performed	
Zi.	Physicien: r this certific ral director,	To Be	25. Was case referred to medical examiner?	domital: Other	Death (Check only one) g Home 5 Residence	a 6 ☐Other (Specify)
Division of Vital Records,	iding Physicien: th. After this certifica	ion: T	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury Injury M 28c. Injury at Work? 1 Yes 2 No	28d. Describe how in	njury occurred
visio	Atter r dea ector by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
۵	Hospitel or 44 hours afte Funeral Dir tely filled in			sician: To the best of my knowledge, death occurred at the time, date and pla		
	the Hos hin 24 hc the Fun npletely	Medical		ner: On the basis of examination and/or investigation, in my opinion, death or and manner stated.		
	with To t	Σ	29b. Signature and title of cat 16	29c. License number		Date signed (Month, Day, Year)
	n		1000	pompleted cause of death (Item 23a) (Type, Print) MD 4801 DOESES FAX RD #222, ELLICE	1717	00400
	3		MICHAELG MALON , 31. Date filed (Month, Day, Year)	132 Reflector's Signature.	PTI CITY, MA	W- 21042
	Sta Regist		APR 2 5	32. Redistrar's Signature.		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amend item#11,19a, per Inf. 1856 6/6/06 TT Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month De VASI **Physician** E. Hendon 10 2006 /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Crofton Convalescent & Rehab Center Crofton Anne Arundel If Under 1 Year If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 78 Yrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days 1200 MM 2□ F Months 01-27-1928 Alabama Director 422-26-5073 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location r than "natural", or items 23e or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No MD Anne Arundel Crofton Funeral Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 2131 Davidsonville Rd. 21114 USA filed within 72 hours efter death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2☐tNo Specify: Specify: White ٥ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondary (0-12) Dept of Commerce US Goverment Ith end Mantel Hygia
7 is marked other traumatic avant, to 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Harold E. Hendon Sr. Willodene B. Hendon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) of Haalth e Elizabeth C. Hendon /wife 5406 Connecticut Av Washington DC 20015 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Chesapeaké Crematory 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 04/22/2006 Beltsville MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility M00382 Rapp Funeral & Cremation Service 933 Gist Av Silver Spring MD 20910 23a. Part1. Enler the Lise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) . Atheroscherotic Condio Vascular Disense /Medical Examiner Atheroscherotic Cerebro Vascular Disturce Physician/Medical Examine To the Hospital or Attending Physician: The lew requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, the 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☐ No After this certific funaral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours eftar death.

To the Funeral Director: Af investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier D20108 CNONG MI)

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)
RAICESH ARORA, MD 14300GALLANTFOX LN, BOWIE, MD20715

			1 - For State Registrar	State of Mar	yland / Depa <i>Cer</i>	tificate of			Reg. No.	96	12775
	Physici /Medio		Decedent's Name (First, Middle, Last CECELIA YVONNE	HILL				2. Date of E Month April	Day 17 .	Year 2006 ty of Death	3. Time of Death
	Examir Funeral	er	4a. Facility Name (If not institution, give 54 Agnes H 5. Social Security Number 6. Se	ospital	(In yrs. last birthday)	4b. City, Town, o	MOI If Under 24	Hrs. 8. Date of 8 (Month, I	Birth Day, Year)	9. Birthpl	lace (State or Foreigr
	Director		219 - 57 - 6634 15 Usual Residence of Decedent 10a. State 10b. County		56 Yrs. Oc. City, Town or Lo	cation		11-3-	1949		YLAND Od. Inside City Limits
	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, I'm Medical Exaction must be notified at	al Director	MD. N/A 10e. Street and Number 1326 N. MOUNT S	ST.	BALTIMO	RE 10f. Zip Code 2121	7		1XXYes 2 □ N 10g. Citizen of What Country? USA		
9036	ours after deat rai', or items 2 Exactions mu	by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:	1	Vas Decedent of H i Yes, specify Cuba	ispanic Origir In, Mexican, I Specity:	n? (Specify Yes or I Puerto Rican, etc.)		ce - America ack, White, e ify: BL.	
21215-0036	드 ·	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) -11-		(Give life, L	lent's Usual Occup kind of work done DO NOT use retired R MAID	during most o			BAR	lustry
Maryland	should be filed with ind Mental Hygiene imarked other tha umatic event, Insti	To Be	17. Father's Name (First, Middle, Last) JOSEPH HILL				MAR	Name (First, Midd			
	nd 2 state are trau		19a. Informant's Name/Relationship (7) WILLIAM BROWN (S)	_	561	1 MORAVIA		or Rural Route Nun BALTIMORE Date	, MARYLA	ND 21	206
Baltimore,	permit. Pages 1 ar Department of Hea Important: if Itam : eny injury or other once.		20a. Method of Disposition 1 Deurial 2 Oceanation 3 4 Donation 5 Other (Specify,		KING MEMO	natory or other plac RIAL PARI	۷ 4-	-21-2006	BALTIMO	RE, M	ARYLAND
Ball	permit. Pag Department Important: i eny injury o		21. Signature of Funeral Service Liveris	O. HiB	new 1	721-27 N	. MONRO	DE ST. BA	LTIMORE,	•	LAND 21217
	Physician /Medical Examiner		23a. Party. Enter the disease, or comp shock or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list on Jilions.	a. Due to (or as a	ridium disconsequence of):	if the mode of dyin			arrest,		Approximate Interval Between Onset and Death
68760, 🔨	icate be executed physician and s the burial-transit	edical Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):						
P.O. Box 68	death certifi e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)				ate of delive	ory Day Year
	quires thet in signed b uld be det	by	Part II. Other significant conditions co			,			d tobacco use cor ☐ Yes 2 ☐ No		ne cause of death?
l Reco	The law requ	Completed	type 2 diabetes m	ellitus, hy	pertrophic	cardio	myop	_ pe	as an 24b. topsy formed?	prior to con death?	psy findings available npletion of cause of 2 \(\text{No} \)
on of Vital Records,	ing Physician: Mer this certific Ineral director,	To Be	27. Manner of Death Natural 5 Pending	Hospital: 1 Inpafient 28a. Date of Injury (Month, Day)	28b. Time of	28c. Injur Wor	er: 4□ Nurs				9
Division	or Atten after deat Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	r - At home, farm, stri (Specify)		763 2	28t. Location	(Street and Num Fown, State)	nber or Rura	l Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in Incompletely Medical	29a. Certifying Phy (Check only one)	rsician: To the best of iner: On the basis of e and manner state	xamination and/or inv id.	estigation, in my o	pinion, death	occurred at the tim	e, date and place	, and due to	the cause(s)	
	Tot Tot com	>	29b. Signature and utile of certifier	Shel	MO, AD	29c. Licens) 6 5 8	309	April (ed (Month, 1	Day, Year)
	C Sta	te	30. Name and address of person who concerns the second of	ompleted cause of dea	MD, AD th (Item 23a) (Type, A C S Ho s Signature	Print) Ital -	900 (aton Av	enve B	altimor	e MD 2120

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death APRIL 23, 2006 Year **Physician** ROBERT HOFFMAN 6:35 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON JAN. 11, 1923 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Min. 1 M 2□ F Hours MD 215-18-7305 83 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or itema 23a or 28a-f ahow other traumatic avent, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director BALTIMORE OWINGS MILLS MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 4730 ATRIUM COURT #111 21117 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 M Yes 2 □ No If Mes, Give Year or Dates: 1 ☐ Never Married 2 Married WWII Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No þ Specify: Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "nany injury or other traumating." Elementary/Secondary (0.12) College (1-4or 5+) **SUPERVISOR** U.S. POST OFFICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be NATHAN HOFFMAN MARY KATZEN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4730 ATRIUM COURT #111 - OWINGS MILLS, MD 21117 HELEN HOFFMAN / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4/24/06 SHAAREI ZION CEMETERY 🗽 ROSEDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final year Concer **Physician** Keirel disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a nonsequance of). Examine sicien and burial-transit Due to (or as a consequence of) 68760. by the attending physicien Physician/Medical as the Box (IF FEMALE esn 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9☐ Unknown o. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 3 probably 4 □Unknown 1 🗌 Yes 2 🗆 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 : this certificate has autopsy performed 1 Yes 2 No 1 Yes 2 No Vital director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Mother (Specify) NOS PICE 1 Yes 2 No ၉ 2 ☐ ER/Outpatient 3 ☐ DOA ō To the Hospital or Attending Phys within 24 hours after death.
To the Funeral Director: After this completely filled in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; Division 1 Matural 5 Pending investigation 1 Tyes 2 No 2 Accident 6 ☐ Could not be 3 🗀 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number April 23 2000 D 58303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARRANI CHARLES MD 6601 N. CHARLEST D Baltomore Não 2,204 Apren Charles mo 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 3:00 P.M Jones APRIL Ellen 22 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 27, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F Director 93 Yrs. Virginia 227-09-9488 1912 Usual Residence of Decedent with the Maryland 10a. State 10b. Count 10c. City, Town or Location r 28a-f ahow 10d. Inside City Limits 1 XYes 2 No Directo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? rel', or Items 23a or Examiner must be 524 N. Charles St., Apt# 1706 21201 U.S.A. Pages 1 and 2 should be filed within 72 hours after death Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No þ 3 ☐ Widowed 4 ☐ Divorced "naturel" al Hygiene. d other than "nature event, the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrician 12 Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mental 27 is marked or treumatic ever ပ Joel Leftwich Jones Sarah Virginia Steffey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 i P.O. Box 212, Thaxton, VA 24174 Shirley H. Dooley (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ö 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Importent: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Oakwood Cemetery 4/27/2006 Bedford, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Tharp Funeral Home & Crematory 320 Ñ. Bridge St., Bedford, VÁ Vallneur Linna 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) NEUMONIA Physician MONTH /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a soneequenes of): physicien and s the burial-transit The law requires that the death certificate be executed Exami resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death signed by the a 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate hes tirector, page 2 s autopsy perform 1 ☐ Yes 2 No 1 🗌 Yes of Vital or Attending Physician: director, 25. Was case referred to medical examiner? To Be 26. Place of Death | Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 SoNo this arel Director: After th 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a To the Funarel I completely filled Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) D 47/23 APRIL elminana 190 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 E. UNTO SEPH PUTHULYANA UNION MEMORIAL HOSP 201 E. UNIV. BALTIMORE JOSEPH PUTHUMANA MAD 31. Date filed (Month Pay, Year) 2006 32 Registrar's Signature (108sta) State All Birth Al Registrar

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	Physic /Medi			homas	John	Bon			Date of Death Month	Pay It	Year 8 A M	
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	Funeral Director			Sex 7. Ag 1 M 2 □ F	e (In yrs. last birthday) 86 Yrs.	If Under 1 Yea Months Days		4 Hrs. 8. (Date of Birth Month, Day, 4-6-20		Birthplace (State or Foreign Country) Va.	
	ith the Maryland or 28e-f show	tor	10a. State 10b. County	JA	10c. City, Town or Lo Balti		.,-				10d. Inside City Limits M☐ Yes 2 ☐ No	
	3e or 28e	Funeral Director	10e. Street and Number 1418 N. Bethel	Street	·	10f. Zip Code 212			10	g. Citizen of W	/hat Country?	
9600	72 hours after death with the Maryland "neturel", or Items 23e or 28e-f show dical Exertifications to nutified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1 0	Was Decedent of If Yes, specify Cui	Hispanic Origir ban, Mexican, I	n? (Specify Puerto Rica	Yes or No- n, etc.)	14. Race	- American Indian, k, White, etc.	
21215-0036	within 72 h ene. then "netu	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5	(Give	dent's Usual Occu kind of work done DO NOT use retin	e during most o red)	of working	1	6b. Kind of Bus	siness/Industry	
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Maryland	should be ind Mental I s marked o umetic eve	2	Thomas 19a. Informant's Name/Relationship		Tohnson 19b. Mailir	ng Address (Stree		erva or Rural Ro	ute Number,		merville State, Zip Code)	
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8760,	Physician /Medical Examiner	dical Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (International Cause) and in the cause in the sequential of the cause in the sequential of the cause in the sequential of the cause in the sequential of the cause in the sequential of the cause in the sequential of the cause in the sequential of the sequ	a. Hy RO Due to (or as a Due to (or as a	the death. Do not ent le	и .	ing, such as ca	/			Approximate Interval Between Onset and Death Horse Thore 2 years	
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Division of Vital	ling Physici After this cer uneral direc	ertification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation		y 28b. Time of	28c. Inju	her: 4 X Nursii	ng Home		ce 6		
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)	To I To I	M	29b. Signature and title of certifier	Trupa	udlin	29c. Licens	3066	6/	290	Date signed ((Month, Day, Year)	
	9		30. Name and address of person who H700 Haugo:	completed cause of de	ath (Nem 23a) (Type, P	Print)	· He	d 2	121	4		
	Sta Registr		31. Date filed (Month, Day, Year) APR 9 5 7	32. Registra	r's Signature	sold .						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Reg. No. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5 52 Month 04 **Physician** Year R JOHNSON HARLES 18 2006 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIV. OF MARYLAND MEDICAL SYSTEM BALTIMORE NA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 07, 27, 1944 Birthplace (State or Foreign Country) **Funeral** Days Hours 10 M 2□F 219-40-2304 MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director NIA Mo BALTIMORE 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21223 122 S. CAREY STREET USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LABORER CONSTRUCTION LAH GRADE NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CHARLES JOHNSON OWIA HOWARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (WIFE JOHNSON 207 N. AMITY STREET CONNIE BALTIMORE MD Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) 04-26-06 BALTIMORE, MO GREENMOUNT 21. Signature of Funeral Service Licenses 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATU PIKE, BALTO. MO 21229 angh 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ORGAN FAILURE 30 hours MULTI disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner B DESCENDING THORACK ADRTIC DISECTION hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) ed by the attending physicien adetached for use as the burial Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy ę in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown cate has been signed by t page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed: 2 No 1 Yes 2 No 1 Yes funeral director. 25. Was case referred to medical Be 26. Place of Death Check only one examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 Z No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b, Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 Z No investigation 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide Hospitel 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 29c. License number 04/18/06 P17699 Monto Name and address of person who com pleted cause of death (Item 23a) (Type Print)

DHMH 17 Rev 1/200

State Registrar 31. Date filed (Month, Day, Year)

2006

ORIGINAL

32. Registrar's Signature

			For State Registrar	State of Maryland / De	epartment of H Certificate of L		ntal Hygier	.000	12780
Ø.		dig.	Decedent's Name (First, Middle, Last)				. Date of Death	-	3. Time of Death
	Physici /Medio		Frank Mich	ael Junghans			4 /	6 2006	6:10 A M
	Examin	er	4a. Facility Name (If not institution, give Survise Assisted		4b. City, Town, or	Location of Death	1 .	Non +90	
8	Funeral		Social Security Number 6. Se	x 7. Age (In yrs. last birtho	fay) If Under 1 Year	If Under 24 Hrs. 8		9. Birtl	nplace (State or Foreign
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	yland oow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	r Location				10d. Inside City Limits
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	with the or 28	Dire	10e. Street and Number Thayer Ave	2211.0	10f. Zip Code 2091	`		Citizen of What Co	untry?
	Jeath ins 23	eral	11. Marital Status					SA 14. Race - Amer	ican Indian.
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 ie marked other than "naturel", or items 23s or 28s-f ehow other traumatic event, the Medical Examinar must be notified at	Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 A.No If Yes, Give Year or Dates:	13. Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 No	n, Mexican, Puerto Ric Specify:	cán, etc.)	Specify: W	
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pu	2 should be filed withir and Mental Hygiene. ie marked other than aumatic event, Ins M.	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name (/	First, Middle, Maide	en Sumame)	
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Mai	and 2 st ealth and n 27 ie n		19a. Informant's Name/Relationship (T) Frances Junghan	1 10	ailing Address (Street a	nd Number or Rural F	i i		ip Code)
re,	es 1 and of Health fitem 27 r other tr		20a. Method of Disposition	20b. Place of D	isposition (Name of	Dat	e 20c.	Location - City or 1	Town, State
Baltimore,	Pag nent ant: I		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Chesape	aka Cromate	mu 4-21-0	16 Be	Itsville	MD
Ball	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service Licens		22. Name and Address	s of Facility Roup & Ve. Silver	Springi	ND 20910	Services
H			23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	ications that caused the death. Do not not cause on each line.	enter the mode of dying				Approximate Interval Between Onset and Death
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<u>α</u>	es that igned b	by Pt	Part II. Other significant conditions cor	ntributing to death but not resulting in th	e underlying cause give	n in Part I.	23e. Did tobacco	use contribute to	the cause of death?
ord	w require been sig should b						1 ☐ Yes	2 No 3 □ Pro	bably 4 Unknown
of Vital Records,		Completed		14 ATT \$100 10 ATT			24a. Was an autopsy performed? 1 ☐ Yes 2 🐼	prior to co	opsy findings available ompletion of cause of 2□ No
Vita	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	dospital:	tiont 20 DOA Cthe	26. Place of Death (C		1	Assisted
	g Physier this	n: To	27. Manner of Death	1 ☐ Inpatient 2 ☐ ER/Outpa 28a. Date of Injury (Month, Day Year) 28b. Tim	e of 28c. Injury	4 🗆 Nuising Home	d. Describe how inj	6 Other (Specury occurred	W Living
sior	ttending later. tor: After the funer	catio	1 Matural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Worth, Bay rear) stiju		r ′es 2 □No			
Division	after d Direct In by	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f	Location (Street a City or Town, Sta		al Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier 1 Certifying Physical Check only one)	sician: To the best of my knowledge, d ner: On the basis of examination and/o and manner stated.	eath occurred at the time r investigation, in my op	e, date and place, and inion, death occurred	d due to the cause(at the time, date a	s) and manner as nd place, and due	stated. to the cause(s)
	To th To th compl	Me	29b. Signature and title of certifier	1/1	29c. License	number	29d. D	ate signed (Month	Day, Year)
	λ		1 What	We upo	D181	37	4/	19/06	
	8		30. Name and address of person who co	ompleted cause of death (Item 23a) (Ty	pe, Print)	on Nation	095		
4	Sta	te	Jeff rey probis 109 31. Date filed (Month, Day, Year) APR 2 5 21	32. Flegistrar's Signature	Angelo B	on in a	10 10		
	Registr	ar	APR 2 5 21	106 Brun 15 1	A CONTRACTOR OF THE PARTY OF TH				

State of Maryland / Department of Health and Mental Hygiene [] [] [1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 12:10 A_M **Physician** MOPRIL 2006 SOON 0K JI. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner STELLA MARIS TIMONIUM BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-06-1914 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1□M XXF 91 KOKEA 219-17-1340 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "neturel", or items 23a or 28a-f ehor the Medical Exportment count be polified at MD. BALTIMORE TIMONIUM 1 ☐ Yes XX No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? KOREA 2300 DULANEY VALLEY ROAD 21093 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, While, etc. 11. Marital Status 1 Yes 2XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: KOREAN 1 Yes XX No 9 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 YEARS College (1-4or 5+) HOUSEWIFE OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi and Mental F ie merked ot YUL SEUNG KIM KAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12240 ROUNDWOOD ROAD, TIMONIUM, MARYLAND, 21093 CHUN C. WOO (DAUGHTER) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ites
any injury or oth HILLTOP SERVICE CORP. 04-26-2006 TOWSON, MARYLAND, 21204 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 YORK ROAD RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD. 21204 R. & Ru (R. G.RUTH) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ere provasculan Physician monks /Medical Due to (or as a consequence of): Examiner Sequentially list conflicts if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physicien end the burial-transit Exami Due to (or as a consequence of): 68760 Physician/Medical r use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 1 Tes 2 No. Vital To the Hospitel or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpalient Other: 4Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2⊠No 2 ER/Outpatient 3 DOA to 28a. Dale of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division Injury 1-8 Natural 5 Pending 1 Yes 2 No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Ptace of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) NM, 52140 syltes Mi 30. Name and address of person who completed cause of death (m 23a) (Type, Print) ERNESTINE WRIGHT, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death arnesh Koricho 2006 County of Death Hospital Center Koseda le

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Himore 5. Social Security Number 7 219-55-2082 6. Sex Birthplace (State or Foreign County) 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 330 Foxalove Square 21017

death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or itams 23s or 28s-1 show any injury or other traumatic event, the Medical Examiner must be notified at 9008. Negash, Waynshet

Baltimore, Maryland 21215-0036

1 - For State Registra

10a. State

ral Director

MD

Physician

/Medical

Examiner

Funeral Director

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director.

Division of Vital Records, P.O. Box 68760, 🥕

1 Never Married 2 Married Widowed 4 Divorced 15. Decedent's E (Specify only highest gr.	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puer 1 Yes 2 No Specify:	opecity Yes or No- to Rican, etc.)	14. Hace - American Indian, Bfack, White, etc. Specify: Black			
15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		Decedent's Usual Occupation (Give kind of work done during most of wo. life. DO NOTUSE retire!)	rking 16b.	Kind of Business/Industry ANUFacturing			
17. Father's Name (First, Middle, Last Negash Kor 19a. L.fo, Jant's Name/Relationship	icho	Gede	me (First, Middle, Maid	Seify			
ISTAL Nec	Gash Brotler 68 20b. Place of cemeter)	Mailing Address (Street and Number or Ri BI + Forderes+ Disposition (Name of , crematory or other place)	Pd, Bal	Location - City or Town, State			
21. Signature of Funeral Service Lice	Sue Sue	Variable Work Land	westinge Balto	ral Services			
23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. He of a a consequence of	ot enter the mode of dying, such as cardiac (f):	c or respiratory arrest,	Approximate Interval Batween Onset and Death			
Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of Due to (or as a consequence	·					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23d. If yes, outcome of pregnancy 1						
Part II. Other significant conditions of	contributing to death but not resulting in	the underlying cause given in Part I.		use contribute to the cause of death?			
			24a. Was an autopsy performed?				
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Other	ath (Check only one)				
27. Mann r of Death 1 Natural 5 Pending 2 Accident investigation		ALIMITSING H	ome 5 Residence 28d. Describe how in				
3 Suicide 6 Could not b 4 Homicide determined	building, etc. (Specify)		City or Town, Sta				
29a. Certifier 1 Certifying Ph (Check only 2 Medical Exar	nysician: To the best of my knowledge, niner: On the basis of examination and and manner stated.	death incoursed at the time, date and plane for investigation, in my opinion, death occur	and due to the cause rred at the time, date a	s) and manner as stated. nd place, and due to the cause(s)			
29b. Signature and title of certifier Atuato	. Wille, MD.	29c. License number D36663		ate signed (Month, Day, Year)			
30. Name and address of person who of Stuar Harmonian (Month, Day, Year) 31. Date filed (Month, Day, Year) 2	completed cause of death (Item 23a) (T	ype. Print) Square Hos		e Baltimore MD 212			

State Registrar

State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend Item #29d G854 4/25/06C Altificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2006 **Physician** Year Alma L. Kukucka 3:25 PM M April 18, /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death 12402 Jerusalem Road Kingsville Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 09/05/1937 **Funeral** 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 68 Months Days Hours 1 M 2 F Min 212-32-8965 Director VA Usual Residence of Decedent with the Maryland Show 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be natified at Director MD Baltimore 1 Yes 2 No Kingsville 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a or 12402 Jerusalem Road 21087 USA Funeral Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Ite 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ♣No If Yes, Give Year or Dates: Specify. Completed by Specify: White 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Banking Elementary/Secondary (0-12) College (1-4or 5+) Title Examiner traumatic svent, 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Carless Lee Clark Beatrice Pruitt 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Kukucka/Son 12402 Jerusalem Road Kingsville, MD 21087 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Apr 20 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny Injury or once. Beltsville, Maryland Chesapeake Crematory 2006 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC /Medical Due to (or as a consequence of): Examiner Sa united his conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Box 68760, △ Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) PO 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 20 No 1 Tyes 3 Probably 4 Unknown Completed peed 24b. Were aulopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 1 Yes 2 🗆 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: ٩ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After Natural Injury 5 Pending neral Director: A death. 1 Tyes 2 TNo investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and thie of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item a) (Type, Print) 4/19/2006 m HUERBACH Philagel DhiA 2. Registrar's Signature State Registrar APR 2 1 2006

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician KIKBU Margaret 74 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Hopkins Baynew If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 21 F Yrs. 215-28-6485 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itsma 23a or 28a-i show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8528 Kavanagh Road 21222 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 📆 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 2 Specify 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Years Homemaker Own Home Pages 1 and 2 should be filed vitment of Heelth and Mental Hygie tant: if itam 27 is marked other jury or other traumatic svent, in 17. Father's Name (First, Middle, Last) Ukn. 18. Mother's Name (First, Middle, Maiden Surname) Lambert Catherine Reinig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles D. Kirby (Son) 8528 Kavanagh Road Dundalk, Maryland 21222 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: if any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery/April 24,2006 Baltimore, MD 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licensee 1922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death Pmil. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiogenic Physician /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a noneequence of) Examine ettending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ NO 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? due 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes been : 24b. Were autopsy findings available prior to completion of cause of death? Shock 24a. Was an performed certificate 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Dinpatient 2 2 ER/Outpatient 3□ DOA Alter this funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident s after dec. 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 1 Destrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certified 29d. Date signed (Month, Day, Year) RESOO! cause of death (Item 23a) (Type, Print) 4940 Eastern AVE, Baltimore mo Chadha, 31. Date filed (Month, Day, Year) 2. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2006

State of Maryland / Department of Health and Mental Hygiene | | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April **Physician** 23 p Mary Viola Lahey a M 2006 9:32 /Medical 4a. Facility Name (If not institution, give street and number)
910 Saxon Hill Drive 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Cockeysville
If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9 - 6 - 1 9 2 2 Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 M 2 XF 83 Yrs Director 214-12-0915 Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at MD 1 □Yes 2 No Director Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? .0 Itams 23a 8620 Kelso Drive Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant If item 27 is marked other than "natural", or Items 23. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 27 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 8 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank Schaech <u>Ida Benhoff</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis Lahey - Son 910 Saxon Hill Dr., Cockeysville, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of P Important: If its any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 4-24-06 Baltimore, MD 22. Name and Address of Facility Bradley-Ashton Funeral Home, 21. Signature of Funeral Se 2134 Willow Spring Rd., 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MetaStatic Adeno carcinoma Priysician disease or condition resulting in death) months /Medical Due to (or as a consequence of) Examiner Adenocaranoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of detivery 3 Ectopic pregnancy Dav Year 4☐ Pregnant at time of death 5 Other (specify) the 9□ Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ this certificate has been signal director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 1 Yes Hospital or Attanding Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 Nursing Home SE Residence 6 ☐ Other (Specify) Certification; To 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Injury s after decreal Diractor: After the form 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai completely 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0061907 Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultimore Mace Avenue MD 21221 2. Registrar's Signature 31. Date filed (Month, Day, Year) 5 2006 Registrar

			. 101	artment of Health and Mer <i>rtificate of Death</i>	ntal Hygiene 006	12786
	*		Decedent's Name (First, Middle, Last)	2.	Pate of Death	3. Time of Death
н	Physici /Medic		Alvin Joseph Lyons, Sr.	<i> </i>	Month Day Year	6 530 PM
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of De	ath
			Maryland General Hospital	Baltimore City If Under 1 Year If Under 24 Hrs. 8.		ore City
14	- Funeral Director		5. Social Securify Number 6. Sex 18 M 2 □ F 7. Age (In yrs. last birthday 81 Yrs.	If Under 1 Year If Under 24 Hrs. 8.		irthplace (State or Foreign Country)
100			Usual Residence of Decedent		7-17-1925	MD
	faryland ebow		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	8a-1 •	cto	MD Anne Arundel Linth	· · · · · · · · · · · · · · · · · · ·		1 ☐ Yes 2 No
	with th	Dire	10e. Street and Number	10f. Zip Code	10g. Citizen of What C	Country?
	eath v	erai	554 Fairmount Road 11. Marital Status 12. Was Decedent Ever in U.S. 13.	21090 Was Decedent of Hispanic Origin? (Specify	VSA Ves or No- 14. Race - Arr	perican Indian
336	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural, or itema 23a or 28a-f ehow other traumatic event, Ite Medical Examinations in Itematal	by Funeral Director	Armed Forces? 1 Never Married 2 Married 1 XYes 2 No	If Yes, specify Cuban, Mexican, Puerto Rica 1 ☐ Yes 2 No Specify:		nite, etc.
215-0036	72 hou	Completed	15. Decedent's Education 16a. Dece	dent's Usual Occupation a kind of work done during most of working	16b. Kind of Busines	s/Industry
21	ithin 7	npie	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		
121	filed w Hygier other th		11 Elec	trician	Electi	rical
anc	ould be f Mental H warked of	Be c	Thomas Lyons			
Maryland 21	2 should be filed with and Mental Hygiene. is marked other than sumatic event, Iran	ို		Bertha Ing Address (Street and Number or Rural Ro		Zip Code)
	nd 2 alth a last tract		Mr. Alvin Joseph Lyons, Jr./son 510	Shipley Road; Linthi	icum, MD 21090	
Je,			20a. Method of Disposition 20b. Place of Disposition			r Town, State
im	Pages nent of thant: If its ury or of		4 Donation 5 Other (Specify) Loudon F	ark Cemetery 4-24-2		e, MD
Baltimore,	permit. Pages Department of Important: If i any injury or o		21. Signature of Funeral Service Licensee 2	2. Name and Address of Facility Sing1 1 Second Ave SW; G1	leton Funeral Ho Len Burnie, MD 2	ome, PA 21061
330			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on sach line.	ter the mode of dying, such as cardiac or re	spiratory arrest,	Approximate Interval Between
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of V	Physician: this certific ral director,	Į.	1 Yes 2 No Hospital: 1 npatient 2 ER/Outpatie		5 Residence 6 Other (Sp	ecify)
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	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, deal (Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, and ovestigation, in my opinion, death occurred a	due to the cause(s) and manner at the time, date and place, and du	as stated. ue to the cause(s)
	To the within To the comp	M	29b. Signature and title of certifier.	29c. License number	29d. Date signed (Mor	nth. Day, Year)
)) ffeet ma	P#84524	April 19,	2006
	20		Rangana Han Madhavan, M. D.	C/o Maryland G	ieneral Hosp	ital
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** APRIL 2005 Ε. Lango Inez /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Glen Burnie Baltimore Washington Medical Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV. 12, 1918 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2XF Months Days Hours Min 87 Yrs. 220-07-7101 MD Director Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28a-f show empty injury or other traumatic event, fre Medical Examination must be notified at once. 1 ☐ Yes 2 No Glen Burnie Director Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 323 Delaware Avenue 21060 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2X No Specify: Baltimore, Maryland 21215-0036 ۾ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Montgomery Wards Collections Manager 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Sarah Williams Parren Buck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pasadena, Maryland 21122 Mr. Terry Lango / son 2006 McKinnon Lane, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State Glen Haven Mem. Park 04/22/2006 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home, P.A. Glen Burnie, MD 21061 M01357 1 Second Ave SW, M. Vaneure 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HALLUNGS ENAV Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4□ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by ANCEN 3 Probably 4 Unknown 1 Tyes 2 No been 24b. Were autopsy findings available prior to completion of cause of death? DIBUMAN 24a. Was an autops s certificate ha 2 00 1 Tes 1 ☐ Yes or Attending Physicien: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Anpatient Medical Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; A completely filled in by the fu investigation 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) in the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signal APRILIB, 2006 H54409 completed cause of death (Item 23a) (Type, Print)

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DHMH 17 Rev 1/2001

Registrar

5 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death ent's Name (First, Middle, Last) MentaIL 2886 **Physician** 10:30 AM /Medical 4c. County of Death : MONG 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth 7. Age (In yrs. last birthday).
Yrs. Social Security Number Birthplace (State or Foreign County) **Funeral** 219-30-0501 1 □ M 2 XF Director Usual Residence of Decedent 10d, Inside City Limits death with the Maryland 10a. State 10b. County 10c. City. Town or Location **show** r then "natural", or items 23s or 28s-f shov the Medical Examiner must be notified at 1 Yes 2 No Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number H8 wenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Was Decedent Ever in U.S. Amed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene Important: if Item 27 is marked other then "natural; or item eny injury or other traumatic event, the Medical Exercited ADES. I □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Tes 1□ Yes 2 No Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working fife. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) her's Name (First, Middle, Maiden Şurname) 17. Father's Name (First, Middle, Last) Be Elliot Rouse Number, City or To 19a. Informant's Name/Relationship (Type, Print) Oc. Location - City or Town, State 20b. Place of Disposition 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice ma 21/33 elstown 23a. Part1. Enfort the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PSEUDOMEMBRANOUS COLITIS Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 2 Fetal death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 No this certificete hes 2 □ No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 1 Tes 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manger of Death 1 Natural 28b. Time of Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D28244 -20-06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FOWZIA TAQI. 7601 OSLER DRIVE TOWSON, MARYLAND 21204

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

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ORIGINAL

32. Registrar's Signature

		1	For State Registrar	State of	Maryland		artment of rtificate of				giene Reg. Ne. ()	Terronical Control	12789		
	Physicia		Decedent's Name (First, Middle, Howard Lawless	Last)	<u> </u>					2. Date of De. Month April	Day	006	3. Time of Death 2:30 AM M		
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	Funeral Director		5. Social Security Number 215-24-4431	6. Sex 7 1 (2 M) 2 □ F	. Age (In yrs. la 77	ast birthday) Yrs.	Months Days		Min.	8. Date of Bird (Month, Da 10/07/	1928	9. B VA	irthplace (State or Foreign Country)		
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Maryland	and and sm	<u>م</u>	19a. Informant's Name/Relationsh Mr. Stephen Lawl			1	ng Address (Stree K Tall P								
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			For State Registrar	State	of Maryla	•	artmen rtificat			ind M		giene Reg. No.	UUb	12	790
	Physicia		1. Decedent's Name (First, Midd	-,,	LEM	ON		_			2. Date of De. Month APRIL	ath Day	Year 200	1	of Death
	/Medic Examin		4a. Facility Name (If not institution Bon Secours	n, give street and n	umber)		4b. City,		Location of	f Death	7.11	4c.	County of Deat		
	Funeral Director		5. Social Security Number 214–62–6878	6. Sex 1 M 2 ☐ F	7. Age (In yrs	. last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bird (Month, Da 12-26-19	th y, Year) 952	9. Birt Co Nort	nplace (Statuntry) n Carol	e or Foreign ina
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9	permit. Pages 1 and 2 should be liled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Instructurati: I flew Z7 is marked other than "natural", or Iteme 27a or 28a-f show any injury or other traumatic event, the Madical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1⅓ Never Married 2 Ma 3 Widowed 4 Divorce	ried Armed F	2 X 1No		Was Decedif Yes, spe	offy Cuba	spanic Orig n, Mexican, Specify:	jin? (Spec , Puerto F	cify Yes or No Rican, etc.)	•	14. Race - Ame Black, White Specify: D	e, etc.	
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O. DOX	The law requires that the death certificate be executed as the best been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live	utcome of pregr birth 2 🗌 Fer gnant at time of nown	tal death 3[⊒Ectopic p ⊒ Other (sp				<u> </u>	2	23d. Date of del Month	very Day	Year
Colds, T	quires thet in signed bi uld be deta	ρ	Part II. Other significant condit	ions contributing to	death but not re	sulting in the u	nderlying o	ause give	en in Part I.			obacco u res 2[ise contribute to □ No 3 □ Pr		of death?
ם בי	The law re ste hes bee page 2 sho	Completed									24a. Was autop perfo 1 Yes		24b. Were au prior to death?	topsy finding completion of	s available cause of
ב ב	cien: sertific ector,	Be	25. Was case referred to medical examiner?	Hospitali				Othe		of Death	(Check only o				
5	To the hospitel or Atending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	lon: To	1 Yes 2 No 27. Magner of Death Natural 5 Pendi	28a. Date	Inpatient 2[e of Injury onth, Day Year)	28b. Time o		Bc. Injury Work	4 🗀 INUE	2	ne 5 Resident		6 □Other (Spec y occurred	afy)	
DIVISION	or Atten after deat Director: s in by the	Certification:	2 Accident invest 3 Suicide 6 Could 4 Homicide deten	not be 28e. Plac	ce of Injury - At ding, etc. (Spec	home, farm, str city)					8f. Location (S City or Tox	Street an vn, State	d Number or Ru)	ral Route N	umber,
	Hospite 24 hours Funeral alely fillex	Medical C	29a. Certifier 1 Certifyi (Check only 0ne) 2 Medica	ng Physician: To the Examiner: On the and ma	ne best of my kr basis of examir inner stated.	nowledge, deat nation and/or in	h occurred vestigation	at the tim , in my op	ne, date and pinion, death	d place, a th occurre	and due to the	cause(s) date and	and manner as I place, and due	stated. to the caus	B(S)
	vithin To the compl	Me	29b. Signature and title of certific	or · · ·			296	. License	number				te signed (Monti		
	2		1019	nes				DC	1450	25		A	PRIL	19,2	500
			30. Name and address of person	Curlo completed cal	USE of death (Ite	em 23a) (Type,	Print)	\wedge	-		NW	HC			
-	Sta Registr		31. Date filed (Month, Day, Year	32.	Registrar's Sign	nature	ري	<u> </u>							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 20, 2006 **Physician** 11:17 AM Mary Jeanette Litz /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Hospital Glen Burnie Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth __ (Month, Day, **Funeral** Min 1□M 2X F Months Days Hours 1928 Maryland February Director 219-22-1097 Usual Residence of Decedent 10c. City Town or Location 10d. Inside City Limits 10a State 10b County in than "naturel", or items 23a or 28a-f show the Medical Examiner must be nutified at N/A Baltimore 1 XYes 2 □ No Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4208 Willshire Avenue 21206 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 72 th and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John F. Cooney Anna Haneschlaeger 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: if Item 27 is n any injury or other traum once. Alfred M. Litz Jr./Son 820 Danza Road Severn Maryland 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Md. Vet. Cem. Garrison Forest 4/24/06 Owings Mills, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Leonard J. Ruck, Inc.
5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service Licensee Christina L. Hilton Ston 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a conseque Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed attending physician and I for use as the burial-transit Due to (or as a consequence of): 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. certificete has been signed by the a rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Division of Vital Records, 1 Yes 2 No 3 Probably 4 Minknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 1 ☐ Yes 2 XNo After this certification funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 XER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 V No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 ☐ Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: , completely filled in by the f 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 5 Hospitai 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of commer 29c. License number 29d. Date signed (Month, Day, Year) NID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print). 10 208 MAG C When 31. Date filed (Month, Day, Year) § 32. Registrar's Signature State APR 2 5 Registrar

		•	For State Registrar	State of Ma			ent of Hea ate of De	ath	Reg	ne - 0 0 6	12792
	Physici		1. Decedent's Name (First, Middle, Last BEATRICE S.	MORTON					Date of Death Month	3 2000	3. Time of Death
>	/Medic Examin		4a. Fecility Name (If not institution, give			4b. Ci	y, Town, or Loc		1110	4c. County of Dea	
7	Funeral Director		Baltimore Washing 5. Social Security Number 216-28-6153	ex 7. Age	Center (In yrs. last birth	day) It Und		Under 24 Hrs. 8 lours Min.	Date of Birth (Month, Day, Y	Anne Arus (ear) 9. Bi 1920	hthplace (State or Foreign ountry) AL
	D.		Usual Residence of Decedent						, chi 20,		
	show	5	10a. State 10b. County		10c. City, Town						10d. Inside City Limits XXYes 2 □ No
	the N	Director	MD ANNE A	RUNDEL	GLEN	BURNII	Zip Code		100	. Citizen ot What C	ountry?
	3a or		42 BROOKS TERRAC	E ROAD			2106	50		USA	,
36	d within 72 hours after death with the Maryland jiene. I then "neturel", or Items 23e or 28e-f show The Medical Examinat must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent B Armed Forces? 1 Yes 2 NN If Yes, Give			_	nic Origin? (Speci lexican, Puerto Ri pecify:	fy Yes or No- can, etc.)	14. Race - Am Black, Whi	te, etc.
215-0036	within 72 hour ene. than "natural' he Medical Ex	Completed b	15. Decedent's E. (Specify only highest gra	Year or Dates: ducation ade completed) College (1-4or 5-		ecedent's U Give kind of ife. DO NO1	sual Occupation work done durin use retired)	n ng most of working	16	b. Kind of Business	BLACK s/Industry
2121	filed with Hygiene. other ther	Com	12		.,	TITL	E ADVIS			MVA	
pu	ed at a	Be	17. Father's Name (First, Middle, Last,)			18.	Mother's Name (iden Sumame)	
Maryland	s 1 and 2 should be f Health and Mental itam 27 Is marked of other traumatic eve	ည	EULIS COLEMAN 19a. Informant's Name/Relationship (Type Print)	19b I	Mailing Addre	ess (Street and	DOVIE		City or Town, State,	Zin Code)
	ulth ar 27 is r trau		RUSSELL MORTON/C	**			STREET		L HEIGHT		0743
Je,	of Health of Health fitem 27		20a. Method of Disposition	70	20b. Place of E	Disposition (f	lame of r other place)	Dat	e 20	c. Location - City o	Town, State
Ë	n 0		1 XBurial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specification)				. PARK	4-26	-06	BALTIMOR	E, MARYLAND
Baltimore,	permit. Pag Department Important: any injury o		21. Synatur of Funeral Service Licer	1. mo	ton	1701-		RENS ST.	BALTIM	ORE, MD	NS F.H., INC. 21217
			23a. Part Inter the disease, or com show or heart tailure. List only	plications that caused one cause on each lin	θ.				espiratory arrest	,	Approximate Interval Between Onset and Death
	Pnysician /Medical	ŝ j	Immediate Cause (Final disease or condition resulting in death)	" EW DY		NAC	DISE	952-			
	Examiner			ATTACK !	consequence of):) CA	Asira	men	DICER	41=	
IA.	vb ≈	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):			- 1,50		
9	and trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (br as a	CONSCIUNCE OF	IOV					
68760,	ificate be executed g physician and as the burial-transit	edical E			ment 1	-					
.O. Box 68	death cert e attending d for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of the first time of the fi	2 Fetal death	3 □Ectopio 5 □ Other				23d. Date of de Month	olivery Day Year
<u>α</u>	ulres that t signed by Id be detad	þ	Part II. Other significant conditions of	contributing to death bu	it not resulting in t	he underlyin	g cause given in	Part I.	23e. Did tobac	1.0	o the cause of death?
of Vital Records,	The law requires that the sate has been signed by the page 2 should be detache	Completed							24a. Was an autopsy performe	prior to death?	utopsy tindings available completion of cause of
ital	ysician: Th is certificate director, pag	Be C	25. Was case reterred to medical examiner?					. Place of Death (
of V	S S	၉	1 ☐ Yes 2 No	Hospital: 1 Inpatie						ce 6 ☐ Other (Spe	ecify)
	ding h. After fune	tlon:	27. Manner of Death Natural 5 Pending investigatio	28a. Date of Injur (Month, Day	y Year) 28b. Tir Inj		28c. Injury at Work?	2 🗆 No	d. Describe how	injury occurred	
Division	or Attan	Certification;	Accident investigation Suicide 6 Could not be determined	B Bloom of Init	ry - At home, tarn . (Specify)				f. Location (Stree City or Town, S	et and Number or F State)	lural Route Number,
	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Medical C	29a. Certifier 1 Certifying Pt (Check only one) 1 Medical Example 1 Certifying Pt (Check only one)	nysician: To the best of miner: On the basis of and manner sta	examination and/	death occurr or investigati	ed at the time, o	date and place, and occurred	d due to the caus at the time, date	se(s) and manner a a and place, and du	s stated. e to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier		Δ	1	29c. License nu	mber	29d	. Date signed (Mon	th, Day, Year)
	1		Detail	m	4).		U43	977	A	AL 19	2000
	5		30. Name and address of person who	completed cause of de	eath (Item 23a) (T	ype, Print)	Ein Bu	me re	A: 21	06).	
54	Sta Registi		31. Date filed (Month, Day, Year) APR 2 5 2006		r's Signature	cotte					

Morton, Beatrice

Curtis McGinnis

06-02644 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar dent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day April 18, 2006 Medical Examiner 1934 hrs Inn 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Dea Baltimore 2200 Eagle Street 9 Birthplace (State or 5. Social Security Number 6. Sex Age (In yrs last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) **Funeral** Foreign Days Hours Director 1 X M Country) 2 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits iny 10b County or items 23a or 28a-f show must be notified at once. 1 X Yes 2 No death with the Maryland Viarviand Director 10e. 10f. Zip Code 10g. Citizen of What Country 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral - American Indian, Black Marital Status Was Decedent Ever in U.S Armed Forces? White etc. Never Married 2 Married 2 No Yes 4 Divorced Widowed If Yes, Give Year 1 Yes 2 No specify. is marked other than "natural" þ 16a. Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life DO NOT use retired) Pages 1 and 2 should be filed within 72 h nent of Health and Mental Hygiene ant: If item 27 is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) the Medical Saltimore, MD 21215-0036 18. Mother's Name (First, Middle, 17. Father's Name (First, Middle, Last) Be (Street and Number or Rural Route Number Mailing Address mother or other traumatic Inh 20b. Place of Disposition (Name of cemetery Date 20a Method of Disposition crematory or other place) 2 3 Removal from State Cremation Department o Donation 5 Other Specify nature of Funeral Service Licens . Do not er dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval rt I. Enter the disease, or complication lure. List only one cause on each line. **Physician** Between Onset and /Medical a Acquired immunodeficiency syndrome Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical AMENDED item#23a,PII,27,perME,g855,5/5/06 TT X UNPENDED attending physician or use as the burial -Box 68760, IF FEMALE 23d Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 V Unknown Cirhosis of liver Completed 24a. Was an 24b Were autopsy findings available certificate has been autopsy prior to completion of cause of To the Hospital or Attending Physician: The law death? performed ✓ Yes 2 1 🗸 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Other₄ DOA Nursing Home 5 Inpatient ER/Outpatient 3 Residence 6 V Other Scene After this 1 🗸 Yes ဥ 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d Describe how injury occurred 27. Manner of Death Certification: 1 X Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) determined Homicide 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical within 2. To the F 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b Signature and title of certifie 29d Date signed (Month, Day, Year) 29c. License numbe O.C.M.E April 19, 2006 amo 30 Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) State rar's Signature

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Η. Patrick Moore 10:01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA Baltimore Union Mem. Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 6-11-32 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ₹M 2 ☐ F 73 231-30-8158 Yrs. Director Va. Usual Residence of Decedent with the Maryland It of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23s or 28s-f show or other treumstic event, the Medical Examinar must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore tX Yes 2 □ No Md. NA Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21239 1518 Stonewood Rd. Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. and 1 fem 27 ie marked other than "natural", or items 23. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by Specify. 3 ☐ Widowed 4 ☒ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher - Princilpal School-Columbus, Ohio 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ODay Lukendrick Moore Wilmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 728 Roscoe Ave., Akron, Ohio 44306 George Lawton Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If eny injury or once. 4-26-06 Owings Mills, Md. Garrison Forest Vet. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 21202 Baltimore, Md. la March F.H. East 1101 E. North Ave. W omen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner MESK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last sete has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably Munknown Be Completed this certificete has been 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes So No 1 Yes 2 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ★ ER/Outpatient 3 ☐ DOA Other: Certification: To 1 ☐ Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation the 24 hours after deatl Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) within 2 the 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Dey, Year) APRIL 19 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Union Memorial 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar APR 2 5 2006

State of Maryland / Department of Health and Mental Hygiene [1] 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** А. м Roberta 1:02 Julia March 18 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 19 Barnestable Court Balto Owings Mills If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Davs Hours Min. (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕅 F Yrs. Director 216-20-8682 82 4-15-1924 N. J. Usual Residence of Decedent nit. Pages 1 and 2 should be tiled within 72 hours atter death with the Maryland intronent of Health and Mental Hyglene. ordent: If tiem 27 ie marked other than "neturel", or itema 23a or 28a-f ehow injury or other treumatic avent, I.e. Madical Exeminant be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Md Balto Towson Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 703 Hampton Lane 21286 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: Black þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) March Funeral Homes N/A 12th Grade Funeral Director 17. Father's Name (First, Middle, Last) Unk 18. Mother's Name (First, Middle, Maiden Surname) Be Theresa Hayes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Victor C. March, Sr - Son 708 Milldam Road, Towson, Md 21286 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. King Memorial Park 4-24-2006 Randallstown, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility March F/H West pich W. 4300 Wabash Avenue Balto, Md 21215 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) BRAST Physician MITASTATIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Physician/Medical Examiner burial-transit to the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. use as the attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. | ed by the a 9 Unknown 9 🗆 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 2 No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) House Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident hours after deat 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 | Homicide within 24 hours atter To the Funeral Dire completely filled in b Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as season.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier. 4 20104. 11 318320 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John RATE 10753 TACKS AS-> 1 ic not out 82. Registrar's Signature Goods 31. Date filed (APR 27. 15 ar 2006 State Registra

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician 8:37A Theodore Α. Miller April 19, 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Bayview If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 ☐ F 59 Yrs. March 2,1947 Utah Director 217-46-1831 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director MD Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 21222 USA 2913 Liberty Parkway Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Itema 11. Marital Status within 72 hours after 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify ģ 3 ☐ Widowed 4 ☐ Divorced 'natural', White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e filed within al Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) Welder Welding permit. Pages 1 and 2 should be fite Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Irene Nelson John Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5023 Wright Ave., Baltimore, MD 21205 Shirley Fisher Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Garrison Forest Vet May 2, 2006 Owings Mills, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 11824 Reisterstown Road line Eline Funeral Home Reisterstown, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death HEAD INJURIES Immediate Cause (Final di ease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Iclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death ed by the a Physi 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Tes 2 No 1 ☐ Yes 2 ☐ No To the Hospitel or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending SUBJECT FELL DOWN STAIRS 1 ☐ Yes 2 No UNKNOWN MMONYMN investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide HOME 2913 LIBERTY PKWY 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number M.D. RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMURE, MD 21287 WOLFE ST. 600 NORTH LINTON 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature State 2006 Registrar

			1- State of Maryland / Depart	tment of Health and M ficate of Death		giene	16	12797
	3# J		Decedent's Name (First, Middle, Last)	1 10 10 10 10 10 10 10 10 10 10 10 10 10	2. Date of De	ath Day	Year	3. Time of Death
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	Director		219-16-5218 1 M 2 M F 96 Yrs. Wusual Residence of Decedent		7 - 21 - 1	909		<u>MD</u>
	land bw		10a. State 10b. County 10c. City, Town or Local	tion			T	10d. Inside City Limits
	Mary	ō	MD Baltimore Middle Ri	1 77 0 W				1 ☐ Yes 2X No
	the	rec	10e. Street and Number	10f. Zip Code		10g. Citizen of	What Cou	ntry?
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1 9	after or Ite	F	1 Never Married 2 Married 1 Yes 2 No	es, specify Cuban, Mexican, Puèrto Yes 2XX No Specify:	rican, etc.)		ck, White,	
Elizabe	within 72 hours after death with the Maryland ene. ene. than "natural", or Items 23a or 28a-f show tha Maylcal Examinar is the mulffert at	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 165 201110 Specify.		Specia	v: Wh:	
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, W	Depared Important in in its sense in its sen		PA.	2134 Willow	Spring	Snton Rd	2122	eral Home,
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ري. ت	w requires that s been signed b should be det	y P	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.	23e. Did t	obacco use con	tribute to t	ne cause of death?
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000	e law re has bei je 2 sho	plet	CHF		24a. Was		Were auto	psy findings available mpletion of cause of
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sio	tend Jeath tor: /	cat	2 Accident investigation 3 Suicide 6 Could not be 389 Place of Injury. At home farm street	M 1 Yes 2 No	006 1	Dem - 4 4 Di		10
Division of Vital Records, P.O.	or A after Direction by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	t, factory, office	City or Tox		oer or Hura	al Route Number,
	spital ours ours illed		29a. Certifier Certifying Physicien: To the best of my knowledge, death or	courred at the time, date and place	and due to the	cause(s) and m	20001 20 0	tated
	24 h E Fur e Fur	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or invesore)	stigation, in my opinion, death occurr	ed at the time,	date and place,	and due to	the cause(s)
_	To the Mospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Me	29b. Signature and title of certifier	29c. License number		29d. Date signe	ed (Month.	Day, Year)
			1 (chy mos	DØ\$63\$54		April	22 :	2006
	3		30. Name and addless of person who completed cause of death (Item 23a) (Type, Pri	int)		1		
_			Majid Cina, 8544 Wheatfield way, Ell	icott City, MD 24	043			
	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature	20				
	State Registrar 31. Date filed (Month, Day, Year) 1. PR 2 5 2006 Registrar's Signature							

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene Joe Louis McFadden

2006 12798

	1- For State Certificate of Death Reg No Reg No									
Physician/ ledical Examiner	Joe Louis McFaddon	Date of Death Month Day April 22, 2006	Year 3. Time of Death 1135 hrs							
	4a. Facility Name (if not institution, give street and number) 301 McMechen Street Apt. 813 4b. City, Town, or Location of Death Baltimore City	40	c. County of Death N/A							
Funeral Director	$\begin{array}{c ccccccccccccccccccccccccccccccccccc$		/DD/YYYY) 9. Birthplace (State or 1941 Foreign CountryS. C							
w any	Usual Residence of Decedent 10a. State 10b. County MD N/A 10c. City, Town or Location Baltimore		10d. Inside City Limits							
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th the Marylan 23a or 28a-f st notified at one Il Director	301 <u>McMehen</u> Street Apt# 813 21217		USA							
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	17. Father's Name (First, Middle, Last) Samuel McFadden 18. Mother's Name (First, Middle, Last) Doshie	irst, Middle, Maiden Wilson	Surname)							
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Baltimore, permit Pages I an Department of Hea Important: If iter injury or other tra	4 Donation 5 Other Specify 22. Name and Address of Facility Chat 5240 Reisterstown	 tman-Har	ris Funeral Home							
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ted sistemater	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated									
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1876 Tifical Tifical Tifical Tifical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 5 Other (Specify) 9 Unknown	230	d Date of delivery Month Day Year							
s, P.O. B ires that the d signed by the detached	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Alcoholism		use contribute to the cause of death? No 3 Probably 4 Unknown							
Records, The law requires frate has been sig page 2 should bb		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of							
Division of Vital Records, lat or Attending Physician: The law requirers after death al Director: After this certificate has been stelled in by the funeral director, page 2 should bettingcation: To Be Completed		performed? 1 Yes 2 N	death?							
Vital Rec ysician: The his certificate director, page o Be Con	25 Was case referred to medical examiner? 26 Place of Death (Check onless and the second of Death (Check onless and Dook Other Nursing Hospital: 1 Inpatient 2 ER/Outpatient 3 Dook Other Nursing Hospital: 1 Inpatient 2 Dook Other Nursing Hospital: 1 Inpatient 2 Dook Other Nursing Hospital: 1 Inpatient 2 Dook Other Nursing Hospital: 1 Inpatient 2 Dook Other Nursing Hospital: 1 Inpatient 2 Dook Other Nursing Hospital: 1 Inpatient 2 Dook Other Nursing Hospital: 1 D		ence 6 🗸 Other: Scene							
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Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death ca within 24 hours after death To the Funeral Director: After this certificate has been signed by the attend completely filled in by the funeral director, page 2 should be detached for use Medical Certification: To Be Completed by Physicia	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and during one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated									
M N	29b. Signature and title of certifier 29c. License number O.C.M.E.		Date signed (Month, Day, Year)							
2	30 Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 2120	01								
State Registrar	State 31. Date filed (Manth Ray Year) 2006 Registrar 31. Date filed (Manth Ray Year) 2006									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death L Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** April 19, 2006 7:26 P Miller Sarah /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford 22 Fort Hovle Road Joppa If Under 1 Year Months Days If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min Months Hours 1 □ M 20 F Director 1933 New Jersey 149-26-5645 Dec. 30. 10a State 10c. City Town or Location 10d Inside City Limits 10b. County 28e-f show other traumatic event, the Medical Examiner reset by notified at 1 Yes 2 No Directo Maryland Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21085 USA 22 Fort Hoyle Road or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 14. Race - American Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify þ 3 Widowed 4 Divorced White "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Caroline Elizabeth DeBaun Jennings Clyde Stewart 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 ts.m any injury or other traum <u>once.</u> 303 Habrey Lane, Hartly, Delaware 19953 Steven C. Miller - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Schuylkill Mem. Park | 4/24/06 Schuylkill, PA 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** cancel una disease or condition resulting in death) /Medical Due to (as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consiguence of Examiner ed by the attending physicien and detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. certificate be Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Tension certificate has been rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Osteoporosis 24a. Was an 2 No Albinism 1 Yes or Attending Physician: After this certific funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of eath 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 🗋 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospitei 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) ths 29b. Signature and title of certifier 00043909 Tep hance 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) 902 Averill Rd Joppa, MD 21085 Linder Stephanie

DHMH 17 Rev 1/200

State Registrar 31. Date filed (Month, Day, Year)

APR 2

32. Registrar's Signature

2006

		-	State of Maryland / Department of Health and 1- For State Registrar Certificate of Death		giene Reg. No. 006	12800
	Physici /Medic		Decedent's Name (First, Middle, Last) RICHARD ALLEN MILBY	2. Date of Dea Month	ath Pay 2006	3. Time of Death
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deal RATING REWARD (LEN BUR CLEN BUR 5 Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs	RNIE	4c. County of Dea	FUNDEL
	Funeral Director		5. Social Security Number 213-30-1855 6. Sex 1 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min Visual Residence of Decedent		7, Year) 9. Bir 1935 MD	thplace (State or Foreign buntry)
	a-f show	ctor	MD ANNE ARUNDEL PASADENA			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	or 28	DIre	10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	ountry?
	s 23e	eral	1974 POPLAR RIDGE RD. 21122 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (5	Specify Ves or No-	USA 14. Race - Ame	arican Indian
920	urs after de el', or item Exambien	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 2 Moo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Street Free No. 1) If Yes, specify Cuban, Mexican, Puer 1 Yes, Sive Year or Dates:	into Rican, etc.)		
21215-0036	permit Pages 1 and 2 should be filed within 72 hours after death with the Marylend Department of Haath and Mantal Hyglene. Importent: if item 27 is marked other than "naturel", or items 23e or 28a-f show any injury or other traumatic event, the Modifiel Exattrant must be multiled at ance.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 16a. Decedent's Usual Occupation (Give kind of work done during most of w	orking	16b. Kind of Business	ŕ
, D	filed w Hygie other t	S		ame (First, Middle,	HEAVY TI	RUCKS
Maryland	uld be Vental rked o	To Be		EA QUASKY		
Mary	12 should h and Men 7 is marke		19a. Informant's Name/Relationship (Type, Print) MARY G. MILBY / WIFE 19b. Mailing Address (Street and Number or 8) 1974 POPLAR RIDGE RD.		-	
	tem 27			Date 21,	A, MD ZIIZZ 20c. Location - City or	
mo	Pages nent of I ant: if its ary or o		1 Bollar 2 to Clarifold C Brainova nom Clare	2006	STEVENSVII	LLE, MD
Baltimore,	permit Depard Import any inj		21. Signature Funed Servic Licens 22. Name and Address of Facility M01411 SINGLETON FUNERAL		SECOND AVE. EN BURNIE,	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	ac or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a. The FART ARLUE			IMEEK
	Examiner	<u>.</u>	Sequentially list conditions, favor leading to the sequence of			5 TEARS
_	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C. C. C. C. C. C. C. C. C. C. C. C. C. C	ASE		54EARS
8760,	cate be executed oblysician and the burial-transit	cal Exa	resulting in death) Last Due to (or as a consequence of): DIABELS MELLITUS			10 JEARS
P.O. Box 68	aath certifi attending p for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of de Month	livery Day Year
	luires that the de n signed by the uld be detached	ρ	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contribute to 'es 2 □ No 3 □ Po	the cause of death?
of Vital Records,		Completed		24a. Was a autop perfor 1 Tyes	med? death?	utopsy findings available completion of cause of
/ita	cian: ertific ector,	Be	examiner?	eath (Check only or		
on of \	ding Phys	tlon: To	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28c. Injury at Work?		lence 6 Other (Spe low injury occurred	cify)
Division	ai or Attendi s after death. ii Director: A id in by the fu	Certification:	2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	Street and Number or R n, State)	ural Route Number,
	To the Hospital or At within 24 hours after or To the Funerel Direct completely filled in by	edical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time and the basis of examiners and the basis o			
)	To the I within 2 To the I complet	M	29b. Signature and title of Certifier W 29c. License number N 451 4		29d. Date signed (Mont	
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	glen B	whie m	5 200 61
	Sta Regista	*	31. Date filed (Month, Day, Year) APR 2 5 2006 32. Registrar's Signature			

		•	For 1 - State Registrar	State of	Maryland		artment of F		Mental Hy	giene	16	2801
			Decedent's Name (First, Middentification)	lle. Last)	-				2. Date of De			3. Time of Death
	Physicia	an	Paul	1	M	Gee		1	April	Day 20	Year 2006	0345 AM
	_/Medic		4a. Facility Name (If not institution	on give street and numb		7000	4b. City, Town, o	r Location of Dec			y of Death	- 3 13 /4
	Examin	er	Northwest	Hosp/tal	501)			. 11stown			altim	ore_
	F		5. Social Security Number		. Age (In yrs. la	ast birthday)	If Under 1 Year		s. 8. Date of Birt		9. Birtho	place (State or Foreign
	Funeral Director		213-09-6695	1⊠M 2□F	88	Yrs.	Months Days	Hours Mir	8. Date of Birt (Month, Da 02/11	y, Year) /1010	Cour	imore, MD.
	_	Ì	Usual Residence of Decedent		00				02/11	/ 1310	Dair	more, mo.
	ylan		10a. State 10b. County	y	10c. City,	Town or Lo	ocation				1	0d. Inside City Limits
	a-f s	cto	MD Hor	ward	M	lest F	riendship	0				1 ☐ Yes 2 No
	or 28	ire	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cour	ntry?
	23a (ai	12488 Barnard	Way				21794		Unite	d Sta	tes
	ams ams	ner	11. Marital Status	12. Was Deced Armed Ford		3. 13.	Was Decedent of H	lispanic Origin? ((Specify Yes or No erto Rican, etc.)	- 14. Ra	ce - Americ	
9	or it	by Funeral Director	1 Never Married 35 Ma	rried 1-Yes 2	No		1 ☐ Yes 2√☐ No	Specify:	,	1	fy: Whi	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f show ent, the Maxical Examination and the mailfied at		3 Widowed 4 Divorce	Year or Dat	es:							
<u>V</u>	nat	Completed		nt's Education est grade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of w	orking	16b. Kind of E	3usiness/fn	dustry
2	withir ane. than	E C	Elementary/Secondary (0-12)	College (1-4					Correi ao	Moint		a Tiloudeau
0 0	filed Hygi ther int,	ပ္	8 17. Father's Name (First, Middle	, Last)		ource	d States		ame (First, Middle,			e Worker
an	d ba	o Be	Joseph E. McGe	-				Annie	V. Kidd		ŕ	
Maryland	should bar and Mental I s markad o umatic eva	은	19a. Informant's Name/Relation			19b. Maili	na Address (Street	1	Rural Route Numbe	er. City or Town	. State. Zic	Code)
<u>S</u>	od 2 s Ith ar 27 ls trau		Evelyn E. McGe	ee (Spouse)					est Frier			
	f and Health tem 27 othar tr		20a. Method of Disposition	(Dpoube)	20b. Pt	ace of Dispo	sition (Name of	11	Date	20c. Location		
ē	Pagas nent of h int: If its ury or o		Burial 2 ☐ Cremation		late		natory`or other pla awn Garde	1	24/2006	Mazzzi	at t ar r	ila MD
Baltimore,	C 00 -3		21. Signature of Funeral Service		CL		2. Name and Addre					ille, MD.
Ba	permit. Depart Import any inj		VK: X	lank 2				11	ubbard Fu			
			23a. Part1. Enter the disease, of	or complications that cau	used the death.				ue, Balti ac or respiratory ar		<u>чр.</u> 2	Approximate
b			shock, or heart failure. Lis Immediate Cause (Finaf	70004		1.	(1				Interval Between Onset and Death
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r	Examiner			Huas	-ladde	12- (1)						Years
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	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	S .								
e e	e be exacuted sician and burial-transit		resulting in death) Last	Due to (o	r as a consequ	ence of):						
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9	tifica ng ph as th											· · · · · · · · · · · · · · · · · · ·
Вох	h cer endir r use	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregnar th 2 DFetal		Ectopic pregnanc	v			ate of delive	,
	deat	sicle	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at time of de		Other (specify)			M	onth	Day Year
P.O.	at the by the	hy	9 🗆 Unknown									
	uires that the death certific signed by the attending E d be detached for use as	by F	Part II. Dther significant condit	Λ	Δ.	-	nderlying cause giv	en in Part I.				he cause of death?
ord	w require been sli should b	ted	chronic re	nal ihsa	tficie	ncy			. ''''	res 2 kulno	3 [] Prot	pably 4 Unknown
ecc	law r as be 2 sh	ple							24a. Was	osy	prior to co	psy findings available mpletion of cause of
<u> </u>	The ate h page	Completed							perfo 1 ☐ Yes	rmed? 22 No	death?	2□ No
Division of Vital Records,	stan: artific ctor,	Be (25. Was case referred to medic examiner?					26. Place of D	eath (Check only o	ne)		
<u>×</u>	hysid his co	2	1 ☐ Yes 2 ☑ No			ER/Outpatie	IL 3 DOA		Home 5 ☐ Resid			y)
n	ng P	.io	27. Manner of Death 1 ☑ Natural 5 ☐ Pend	28a. Date of (Month)	Injury , <i>Day Year)</i>	28b. Time o Injury	Wo		28d. Describe I	now injury occu	rred	
sio	death. ctor: A y the fu	cati		tigation				Yes 2 □ No				
$\overline{\underline{\mathbf{z}}}$	or Ati fiter d iraci n by	Certification:	4 Homicide deter	mined 200. Flace C	of Injury - At hor g, etc. <i>(Specify,</i>	me, farm, st	reet, factory, office		City or Tov		ber or Hura	al Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be exacuted within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		20a Contina	ing Physician T- 45	and of multime	ulode= 1- 1	h agains during the	mo deta a del	an and due to the	201102/-		totod
	Hosi 24 ho Fune Fune	lica	29a. Certifier 1 Certify (Check only one)	ing Physician: To the bas I Examiner: On the bas and manne	sis of examinati	viedge, deat ion and/or in	n occurred at the till vestigation, in my d	me, date and pla opinion, death oc	ce, and due to the curred at the time,	cause(s) and m date and place	ianner as s , and due to	tated. o the cause(s)
	thin it	Medical	29b. Signature and title of certifit		., stated.		29c. Licens	se number		29d. Date sign	ed (Month,	Day, Year)
1	E S E S		D R	/	V ^	W	1 -	15844		April	20	2006
,	5+1		30 Name and address of	n upo completed			Print)			7.	,	
1	1		D Rody	5400 Old	Canalitiem	(Type,		08 RG	indallstow	n mo	2 11	33
	Sta	te	31. Date filed (Month; -Day, Year		gistrar's Signat	uje aju	and b	- 0 , 90			av.	<i>y</i> -
	Registr		តពិក <u>ិ</u> ០	5 2006	due F	I P	The Party					
			APR 7.	A CUUUI AM	1	- 5						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** LORENA DIANE MEADOWS - WAY 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TOWSON GILCHRIST NURSING HOME BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1 □ M 2**63** F 220.66.1748 50 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits ir then "natural", or Items 23s or 28s-f ehow the Miclical Examiner must be notified at 1 XYes 2 No NIA BALTIMORE Funeral Director MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4 B2 CT. 1801 DALHOUSIE 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No 1 Yes 2 No Specify: Specify: BLACK ģ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ACCOUNTANT STATE OF MD YRS 1214 GRADE If Item 27 is marked other or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any lighty or other traumatic event 2008. ANNA CARTER LORENZO MEADOWS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1010 MARLAU DR. EBONIE N. GEE (DAUGHIER) BALTO. MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 04.22.06 4 ☐ Donation 5 ☐ Other (Specify) DULANNEY VALLEY TIMONIUM, MD 21. Signature of Fun ral Service Licensee 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 5151 BAUTO NATE PIKE BALTO, MD 21229 Approximate Interval Between Onset and Death, Immediate Cause (Final disease or condition resulting in death) teo SArcomA Physician months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4 Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide To the Hospital or within 24 hours att To the Funeral DI completely filled in To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number

State Registrar 6 BMC

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. Charles St. Balto. md 2 1204 6701

mo

025205

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Records,

Division of Vital

Amend item#8, perFH, C854, 4/28/00 IT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 2:40 AM APRIL 20 2006 Kimberly Marlene Macy /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Agnes Huspital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 2/8/1943 9. Birthplace (State or Foreign (Month. Day, 1947) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 1 2 F 63 Yrs. Director 218-40-4594 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Iteme 23a or 28a-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 763 Carbide Drive 21158 USA Funeral within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other then " any njury or other traumatic event, the MeagnGt. Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Albert Parinello Ella Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Brown/Daughter 763 Carbide Drive Westminster, MD 21158 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Apr 22 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Inc. 2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives MD1943 La due Keller 8717 Green Pastures Drive Baltimore, Maryland 21286-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Enterocolic month /Medical Due to (or as a consequence of): Examiner with severe adhesiums bowel Imall Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner -transit 2 Weeks certificate be executed Sepsis trom and physician ar s the burial-to Due to (or as a consequence of): Physician/Medical use as t ettending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) signed by the e Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ cate hes been sig page 2 should b 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate hes autopsy performed? 1 ¥ Yes 2□ No 1 Yes 2 No completely filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 3□ DOA Director: After this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural 5 Pending death. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct 4 Homicide 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Sashi-AS24385283527 APRIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD Bashi-St Agnes 21229 Ituspital Caton Ave 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

*Ximber 17

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year YVONNE **Physician** MACKLIS CATHY 6. 20AM APRII 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARBOR HOSPITAL CENTER BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F Yrs. Director 216-82-1060 45 11-17-1960 Maryland Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits ?7 is marked other than "natural", or Itams 23a or 28a-1 show traumatic avant. It's Modical Exterilibrit aut be notified at 1 XYes 2 No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 803 N. Fulton Avenue 2nd Floor 21217 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be tiled within 72 hours after of and Mental Hygiene. is marked other than "natural", or Itar 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If itam 27 is marked any injury or other traumatic average. Willie Macklis Sadie Lovett ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cathy M. Lloyd/ Daughter 803 N. Fulton Avenue 2nd Floor Baltimore, MD 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04-21-06 King Memorial Park Randallstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ones 0. Wylie Funeral Home 638 N. Gilmor Street Baltimore, MD 21217 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ERVICAL ONEYEAR Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed Due to (or as a consequence of): physician at s the burial-t Box 68760, Physiclan/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ SACRAL DECUBITOUS ULCE INFECTED 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed ANEMIA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 37 NUTRITION ₽ No 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ျ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours tha Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated within To tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) APRIL 17 2006 RES 000 amati 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAMATHA PRABHAKAR, 3001, MARYLAND STREET DR MAMATHA 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar 2006

	1	For State Registrar	State of Marylar		irtment of <i>tificate of</i>			ene 06	2805
Physician	1	1. Decedent's Name (First, Middle, Last James Bari		nis			2. Date of Death April 23	3, ^{Day} 2006 Year	3. Time of Death 12:45 a M
/Medica Examine Funeral	r	Roland Park Place Social Security Number 215–18–6742	street and number) CE x 7. Age (In yrs.		4b. City, Town, Balti If Under 1 Yea Months Days	r If Under 24 Hrs.		4c. County of Death	nplace (State or Foreign intry) nnsylvania
Director **Brown te page 1		Usual Residence of Decedent 10a. State 10b. County MD Balti	10c. Ci	ty, Town or Lo			Jept 10,	1910 161	10d. Inside City Limits
h with the	5	P.O. Box 4473			10f. Zip Code 21	093	100	g. Citizen of What Co.	untry?
So sun	by rur	11. Marital Status 1 □ Never Married 2 □ Married 3 ★ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1X Yes 2 ☐ No UU If Yes, Give Year or Dates:	II 13. V	Vas Decedent of f Yes, specify Cu □ Yes 2√ No	Hispanic Origin? (Sp ban, Mexican, Puerto o Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Amer Black, White Specify:	
within 72 h within 72 h ene. then "natu he Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation (e completed) College (1-4or 5+)			upation e during most of work ed) 1 1 Counse		6b. Kind of Business/l	·
Jana A	o Be	17. Father's Name (First, Middle, Last) John C.	Maginnis			18. Mother's Nam	e (First, Middle, Ma	aiden Sumame) Tobin	
and 2 shot and 2 shot saith and N n 27 is ma ier traumai		19a. Informant's Name/Relationship (T) James B. Maginnis	s, Jr. –son	211	03 Kimri	ck Pl., T	imonuim,		
SCALLIMOTE, Permit. Pages 1 ar Department of Heam poortant: If Itam my injury or othe moe.		20a. Method of Disposition 1 X8urial 2	Removal from State	cemetery, cien w Cathe		metery 4/	26/06	Baltimore,	MD
permit Depart Import any in		Mell	(43 935 24		1050 Yo	rk Rd., T	owson, MD		ome, inc.
Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	lications that caused the dea ne cause on each line. a	Pa	Λ	ring, such as cardiac		st,	Approximate Interval Between Onset and Death 2075
iticate be executed physician and ts the burial-transit	edical Examiner	Sequentially list conditions, it as y, leading to minimaliate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect Due to (or as a consect d.						
death certii	Physician/med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of a 9 Unknown	aidéath 3□	Ectopic pregnan Other (specify)	cy		23d. Date of deliment	very Day Y <i>e</i> ar
The law requires thet the the has been signed by the bage 2 should be detached.	2	Part II. Other significant conditions co	ntributing to death but not re	sulting in the ur	nderlying cause g	iven in Part I.	23e. Did toba	cco use contribute to	
a sa a	Completed						24a. Was an autopsy performe	prior to o death?	opsy findings available ompletion of cause of
OT VICE Physician: r this certific ral director,	0 0	25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3 DOA		th Check only one	ce 6 Other (Spec	ofu)
To the Hospitel or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	ation	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. inj		28d. Describe how		
To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Alter compietely filled in by the funerel	Certific	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Speci	fy)			City or Town,		
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To ti within To ti	Ž	29b. Signature and title of certifier	Alkern)		5662	290	d. Date signed (Month	, Day, Year)
10+1		30. Name and address of person who come the second of the	ompleted cause of death (Ite	3:	Print) 333	v. Calv.	ert St.	Batto. L	11.21218
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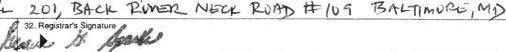
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year April 23, Edmund Charles Mech 2006 5:20 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Rossville Rossville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. June 1, Day 921 6. Sex 1**XX**M 2□ F 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Pennsylvania 203-05-4843 84 Yrs Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a or 8302 Sagramore Road 21237 **USA** Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after tVDYes 2 No IfYes, Give WW∐ Year or Dates: 1 ☐ Never Married 2 ☐ Married 5 1 ☐ Yes 2 🕅 No Specify: Specify: White ģ 3 Widowed 4 □ Divorced natural'. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Millwright Mechanic Bethlehem Steel permit. Pages 1 end 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth eny injury or other treumatic event, pice. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Mech Rose Kempa Schramma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosalie M. Windham/Daughter 8302 Sagramore Road Baltimore Maryland 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Gardens of Faith 4/26/06 Baltimore Maryland 21. Signature of Funeral Service Licensee Christina L. Hilton Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 hustina 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER LUNG Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any leaders of conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a cons a uence of or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) physicien Physician/Medicai the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð cate has been signated by page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 **2 N**o 1 ☐ Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Certification: To 1 ☐ Yes 2 🔀 📢 o 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After s after dec. 1 ANatural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D the Hospital 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b/Signature 29c. License number

State Registrar

31. Date filed (Month, Day, Year) APR 2 5 2006

PANKAI KHETERPA



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records,

10060560

APRIL 24, 2006

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Roberta M. Mitzel April 20 2006 4:42 p.m. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 F Director Yrs. 219-05-7719 85 Dec. 4, 1920 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Deportment of Health and Mental Hygiene.

Deportment: if Item 27 is marked other then "natural; or iteme 23a or 28a-f show eny injury or other treumatic event, it a Medical Engineer; matter and once. 1 ☐ Yes 2 ☐ No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1102 Middleway Road 21220 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: White Specify: 3√Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8th. Grade Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ٥ William Echenrode Lillian Welk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21085 Walter F. Mitzel, Sr./Son 2300 Dunwood Lane, Joppa, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State
Donation 5 ☐ Other (Specify) April 24, 2006 Baltimore, MD Moreland Memorial ure of Finery ervice Licensee 21. Sign 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc. 6415 Belair Road, Baltimore, MD 21206 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 15chemic days /Medical Examiner conary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine as the burial-transit end Due to (or as a consequence of): ettending physicien Physician/Medical IF FEMALE: P FEMALE.
23b. Was deceden pregnant in the past 12 pronths?
1 ☐ Yes 2 ☑ No 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) ed by tha e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2 No 1☐ Yes 2☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOS plc(After this c ٩ 27. Manner of Death

1 Natural
2 Accident Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No efter death Director: / I in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗀 Homicide within 24 hours e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) and un D 58303 APRIL 20 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Λh AARON CHAMINES M 6600 Charles St BALTIMOR UM 21204 N. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State APR 2 5 2006 Beur Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	A	mend item #8 Per FH G854 4/2	5/06 JHCertifica	ite of Death	Reg.		
P	Physician	Decedent's Name (First, Middle, Last)	, A.S.	10 10	Date of Deeth Month	Day Year	3. Time of Death
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-	Examiner	4a Fecility Neme (If not institution, give street end number)		4b. City, Town, or	Location of Deeth	4c. County of Death	·
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	Funeral Director	214-58-7428 10M 20F	64 Yrs. Month	ler 1 Year If Under 24 Hr. s Deys Hours Mir		9. Birthplac Country	S.C.
	pu »	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location			10d	. Inside City Limits
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	ulter death with the Ma r theme 23a or 28a-1 s niner must be notified Funeral Director	11. Marital Status 12. Was Decedent E Armed Forces?	If Yes, sp	edent of Hispenic Origin? (becify Cuben, Mexican, Pue	rto Rican, etc.)	14. Race - American Black, White, etc	
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8	led within 72 hours after death with the Maryland ygiene. Not than "natural", or items 23s or 28s-f show it, the Medical Examiner must be notified at Completed by Funeral Director	15. Decedent's Education	16e. Decedent's Us	sual Occupation	168	o. Kind of Business/Indus	stry
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212	the the	Elementary/Secondary (0-12) College (1-4or 5-4 Baer School	Disak	oled		NA	
73	other vent, per Co	17. Father's Neme (First, Middle, Last)	1	18. Mother's Na	me (First, Middle, Mai	den Surname)	
Maryland	ges 1 and 2 should be filed within it of Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, the Manager To Be Comp	Henry B.	Owens	Hannah	1	Liedy	
2	mari mari	19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Addre	ss (Street and Number or F			ode)
N	d 2 strate	Shirley H. Stokes Careta		alloway Ave.,			
	1 and Health em 27 other tr	20a. Method of Disposition	20b. Place of Disposition /N	leme of		. Location - City or Town	ı, State
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Baltimore,	permit. Pages 1 and Department of Health mportant: If Item 27 any Injury or other to	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	King Mem.	PK . and Address of Facility	4-26-06	Randallst e, Md. 212	
Ba	Depa Impo Impo Piny I	21. Signature of Fulleral Service Licensee			Baltimor	e, ma. 212 1. North Ave	
		Glady Ware	~ Mar	ch F.H. East	1101 E	. NOLLII AVE	· •
-	Physician /Medical Examiner	resulting in death)	TATIC COLOR	V CANCER	ac or respiratory arrest,	ln i	pproximate terval Between nset and Death
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o,	tificate be axecuted g physician and as the bunal-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events	Due to (or as e consequence o	f):			
K 68760,		Cause (Disease of Injury that initiated events resulting in death) Last	Due to (or as e consequence of):			
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-	he a he s	Part II. Other significant conditions contributing to death but	t not resulting in the underlying	cause given in Part I.	23b. Did toba	cco usa contribute to th	ne cause of death?
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>	Physician: The law this certificate has brail director, page 2 s. TO Be Comple	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatien	nt 2 ER/Outpatient 3 [OOA Other: 41 Nursing	Home 5 ☐ Residence	e 6 □Other (Specify)	
10	arthi neral	27. Manner of Death 1 Month, Dey (Month, Dey	y 28b. Time of Injury	28c. Injury et Work?	28d. Describe how i	njury occurred	
<u>ö</u>	Attending or death. octor: Affar by the fune fileation	1 ☑Natural 5 ☐ Pending (Month, Dey 2 ☐ Accident investigation	M	1 ☐ Yes 2 ☐ No			
Division	Attender de cho	3 Suicide 6 Could not be determined 28e. Place of Injurbuliding, etc.	ry - At home, farm, street, facto	ory, office	28f. Location (Stree City or Town, S	t and Number or Rural R	oute Number,
Ö	s aft of in Dir		(-73)				
	To the Hospital or Attending Physician: The law requiras that the death cert within 24 hours after death. To the Funeral Director: Attar this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be datached for use. Medical Certification: To Be Completed by Physician/M	29a. Certifier (Check only 2 Medical Examiner: On the besis of e	examination end/or investigation				
	thin 24 thin 24 the F mplete	one) end menner state	ted.				
	or viti	29b. Signature and title of certifier		9c. License number	29d.	Date signed (Month, Da	y, rear)
	r	> Cuyandano MC	/	216619	1	prik 19, =	XOOL
		30. Name end eddress of person who completed cause of de-	eth (Item 23a) (Type, Print)			45 01011	
	× 11		:040 MARFORI	D16619 D RD BALT	IMORE, A	1D. 21214	
	State	31. Dete filed (Month, Dey, Year) 32. Registrer	r's Signature				
	Registrar	ADD of Course Marie .	R. Da Dan Land				

Amend item#5, perfil, \$55,5/2/00 II

			For State Registrar	State of	Marylan		artment o rtificate			nd M	ental Hy	giene Reg. No.)06	12809
A	Physici /Medi		1. Decedent's Name (First, Midd Marian		Oliver						2. Date of De April		2006 ^{Year}	3. Time of Death B:20 p м
	Examir		4a. Facility Name (If not institution Edenwald	on, give street and num	iber)		4b. City, To		Location of	Death		4c. B	County of Death altimore	3
	Funeral Director	8	5. Social Security Number	6. Sex 1 ☐ M 2 ☐ X F	7. Age (In yrs. 85			/ear lays	If Under 2 Hours	Min.	Jan 6,	th 19, 192	9. Birth	nplace (State or Foreign Misylvania
first.	Maryland show	tor	Usual Residence of Decedent 10a. State 10b. Count MD Ba) ltimore	10c. Cit	ty, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 No
	h with the 23a or 28a at be not	ai Director	10e. Street and Number 800 Southerly	Road			10f. Zip Co	^{ode} 286					zen of What Co	untry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinatment be notified at 2006.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Ma 3 ☒ Widowed 4 ☐ Divorce	If Vas Give	ces? 2 🔀 No 3		Was Deceden If Yes, specify 1 ☐ Yes 2 💢	Cuban	spanic Orig , Mexican, Specify:	in? (Spe Puerto I	cify Yes or No Rican, etc.)		14. Race - Amer Black, White Specify: Wh	, etc.
Maryland 21215-0036	d within 72 ho giene. or than "natur ine Madicul	Completed	15. Decede (Specify only highe Elementary/Secondary (0-12)	nt's Education est grade completed) College (1-	4or 5+)	(Give	dent's Usual C kind of work of DO NOT use i	tone du	tion uring most	of workii	ng		nd of Business/I Bank	ndustry
/land	uld be file Mental Hy arked othe	To Be C	17. Father's Name (First, Middle C. Lee	Murray					18. Mother Ida		(First, Middle Jeane		Sumame) Hau	Π
, Mar	and 2 sho ealth and I m 27 Is mu		19a. Informant's Name/Relation James C. Oliv			819)rohome	r P		Balt:	imore,	MD	Town, State, Z 21 21 0	
Baltimore,	Pages 1 Iment of H tant: If ital		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Specify)	Cla	emetery, crei aysvill	esition (Name matory or othe Le Ceme	r place, ter	У	4/25		Cl	cation - City or 1 aysvill	e, PA
Ball	Depending in months of the mon		21. Signature of Funeral Service			1	050 Yo	rk	Rd.,	Τοωε	son, MD	21	uneral 204	Home, Inc.
18	Physician /Medical		23a. Part1. Enter the disease, c shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	at only one cause on ea	ach line.	nstn		,						Approximate Interval Between Onset and Death
68760, <	Examiner physician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (c	or as a conseq or as a conseq or as a conseq	juence of):	ens s	de	no to	-	di	eas	2	10 ym
P.O. Box 68	ath certifi attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		th 2 ☐ Feta int at time of d	I death 3[Ectopic pregr Other (special					2	23d. Date of delivership	very Day Year
	The law requires that the site has been signed by th bage 2 should be detache	by	Part II. Other significant condit	ions contributing to dea	ath but not res	ulting in the u	nderlying caus	e giver	n in Part I.		23e. Did t		se contribute to	the cause of death?
al Records,	n: The law re Icate has bee r, page 2 sho	Completed									24a. Was autor perfo		prior to c death?	opsy findings available ompletion of cause of 2 No
Division of Vital	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. To the Funaral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	ation: To Be		Hospital: 1 _ In 28a. Date of (Month igation		ER/Outpatier 28b. Time o Injury		Other Injury a Work?	4 Nur	sing Hon	(Check only one 5 ☐ Resident	dence 6	Other (Spec	ify)
DİXİ	To the Hospital or Attending within 24 hours after death. To the Funaral Director; After completely filled in by the fune	Certification:	4 Hollicide	mined 286. Place of building	of Injury - At he g, etc. <i>(Specif</i>	(y) 					City or Tox	wn, State)	'	ral Route Number,
	To the Hospital within 24 hours a To the Funaral Completely filled	Medical		ng Physician: To the base and manners	pest of my kno sis of examina er stated.	wledge, death				place, a				
)	Wil To		29b. Signature and title of certifi	M-	Phs	ican			number	69			signed (Month)	
	8		morcelino	who completed cause	erre	n 23a) (Туре,	Print) 5 (6 A	1. K	20/11	m/	ad B	n lx	hyl	2/228
気が	Sta Registr		31. Date filed (Month, Day, Year	32.	gistrar's Signa	lure	and i			9				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death dent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 7 27A.M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street **Examiner** 8. Date of Birth 9. Birthplace (State or Foreign (In yrs. last birthday **Funeral** Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
ant: If item 27 is marked other then "neturel", or Items 23a or 28e-f show ury or other freumetic event. The Medical Examinar Institle notities at 10d. Inside City Limits 10c. City, Town or Location 10b. County Baltimore 1 XYes 2 ☐ No **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 261 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces? I XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) (First. Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be osanna 19b. Mailing Address (Street and Number or Rural Route Number, City of I permit. Pages 1 and 2.
Department of Health a mpcrtent; If item 27 is any njury or other treusure. Method of Disposition Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Approximate Interval Between Oaset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) and Il-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial Records, P.O. Box 68760. Physician/Medical the as use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 4☐Pregnant at time of death ☐ Yes 2 ☐ No the 9 Unknown 9 Thknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform Yes 1 ☐ Yes 1 Yes 2 No Division of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other. 2 ER/Outpatient 1 Yes 2 No 1 Inpatient P 3□ DOA Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Direct 4 - Homicide Terrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 07930 0 of death (Item 23a) (Type, Print)

Registrar

22

Feldman, M.

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Jane Blount Petersen 4-18-2006 8:15 РМ /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 108 Vista Avenue Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-29-1928 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🖾 F Director VA 223-36-1330 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at 1 □Yes 2 No Funeral Director Glen Burnie Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 U.S.A. 108 Vista Avenue 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritaf Status filed within 72 hours after 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: white Specify: þ 3 K Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Efementary/Secondary (0-12) Colfege (1-4or 5+) Telephone Telephone Operator 12 Description of Health and Mental Hyging Department of Health and Mental Hyging or other Programs of the 27 is marked in Jury or other Programs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Grover Joe Blount Norah Annie Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4600 Linden Avenue; Halethorpe, MD 21227 Mrs. Ann-Marie Grusch / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XD Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park | 4-24-2006 Glen Burnie, MD 4 Donation 5 DOther 21. Signature Juneral Service Licensee 22. Name and Address of Facility Singleton Funeral Home, PA 1 Second Ave SW; Glen Burnie, MD 21061 401411 23a. P.mt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pt IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diahales Melliles 23e. Did tobacco use contribute to the cause of death? Ď 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No After this certificate has 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only ope) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 1 Natural 5 Pending Injury 1 Tyes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20023811 onath an 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5. Crain #304 Glen Burnie MD 21061

DHMH 17 Rev 1/2001

State Registrar 1406 B

MD

32. Pegistrar's Signature

Torman

		1- For Amend Item 1 Registrar		arylan G854	d Dep ,04/28	/06di rtificat	t of ⊢ e of i	lealth a Death	and M	lental Hy	giene Reg. No.)((6)	128	12
Physic	cian	Decedent's Name (First, Middle, Last)							2. Date of De Month	aath Day	Year	3. Time of	Death
/Med		Ronald	0.		P	itt		Sr		April	20,	2006	5:40	РМ
Exam	iner	4a. Fecility Name (If not institution, give				4b. City,	Town, or	r Location o	f Death			ounty of Death		
		1103 Leonard Driv					ı Buı		741100			ne Arun		
Funera		5. Social Security Number 6. Se 213-30-2159	x 7. Ag]M 2□F	ge (<i>In yr</i> s. 72	last birthday) Yrs.	Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bil (Month, Da	ay, Year)		place (State ontry)	ir Foreign
Directo	r	Usual Residence of Decedent								May 29	,1933	MD		
land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							0d. Inside Ci	ity Limits
Many if eh	ţ	MD Anne Arun	de1	Gle	n Burn	ie							1 🗌 Yes	2 📉 No
r 288	Director	10e. Street and Number				10f. Zip	Code				10g. Citize	n of What Cou	ntry?	
h wit	E D	1103 Leonard Driv	'e			210	060				U.	S.A.		
deal	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		.S. 13.	Was Dece	dent of H	lispanic Orig	gin? (Spe	ecify Yes or No		Race - Americ Black, White,		
or fit		1 ☐ Never Married ŽÕ Married	1X Yes 2 ☐ If Yes, Give Year or Dates:	No	i	1 ☐ Yes		Specify:	,	, 110411, 0101,	9		ite	
ural!	d by	3 Widowed 4 Divorced		_										
nat nat	ete	15. Decedent's Edu (Specify only highest grad			16a. Deced		rk done	durina most	of workii	ng	16b. Kind	of Business/In	dustry	
withir and the man	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	Super			2)			ъ	efinery		
Hygin Hygin	S	17. Father's Name (First, Middle, Last)			Super	VISUI		18. Mothe	r's Name	(First, Middle				
d be entai	To Be	Owens W. Pitt						Clara	. D T	0-1-1-				
at y railed & I.K. I.C. COOO. should be filed within 72 hours after death with the Maryland nd Mental Hygiene. n marked other then "natural", or iteme 23a or 28a-f show umatic event, the Medical Examinar must be notified at	F	19a. Informant's Name/Relationship (7)	rpe, Print)		19b. Mailir	ng Address	(Street				er, City or 7	own, State, Zip	Code)	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 le marked other then "natural", or lieme 23a or 28a-f show important: if item 27 le marked other then "natural", or lieme 23a or 28a-f show pringuy or other traumatic event, the Medical Examinar must be notified at		Mrs. Beverly Pitt	/ Wife		1103	Leon	nard	Drive	e G1e	en Burn	ie, M	aryland	21060)
Pages 1 and 2 nent of Health a nnt: if item 27 is		20a. Method of Disposition			Place of Dispo	sition (Na	me of	ne)		ate	20c. Loca	tion - City or To	own, State	
Page Bent c		1 XBuriat 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other Specify)			dar Hi			A	Pril	27,	Broo	klyn, M	D	
permit. Departm Importa any inju		21. Signature of Superat Service Licens	66		22	2. Name a	nd Addre				Fune	ral Hom	e. P.A	
	3	1 Ulle		401								, Maryl		
		23a. Part I. Enter the disease, or composhock, or heart failure. List only o	ications that caused	d the deat	h. Do not ent	ter the mod	de of dyin	ng, such as	cardiac o	r respiratory a	arrest,		Approximate Interval Bet	ween
Physician	1	Immediate Cause (Final disease or condition	•	Me.	lo_t	ulie	1) اعدا	\sim	ance			set and t	Death
/Medica Examine		resulting in death)	Due to (or as	a conseq	uence of):		-0	, no l					g	
Examine		Sequentially list conditions, if any, teading to immediate	b											
ed sit	Examiner	rif any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseq	uence of):									
be executed icien and burial-transit	xar	that initiated events resulting in death) Last	c Due to (or as	a conseq	uence of):									
cate be executed physicien and the burial-transit			d											
ificate p phy:	Physician/Medical	235-	U											
nding use	Z ₩	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome			Je					23	d. Date of delive	ery	
death de ette	Cla	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a			∃Ectopic p ∃Other (s		<u> </u>				Month	Day	Year
by th	hys	9 Unknown	9□ Unknown											
The law requires that the death certificate are been signed by the ettending physpage 2 should be detached for use as the	by P	Part II. Other significant conditions co	ntributing to death b	out not res	ulting in the u	nderlying (ause giv	en in Part I.		23e. Did	tobacco use	contribute to t	ne cause of d	leath?
w require been sl	ed									1/20	Yes 2	No 3 ☐ Prot	ably 4 🗆	Jnknown
law a	ple									24a. Was		24b. Were auto	psy findings mpletion of c	available
sician: The law s certificate hes t	Completed										ormed?	death?	2 No	
cian: ertific	Be	25. Was case referred to medical examiner?							of Death	(Check only	one)			
Physi this o	2	1 Tes No	Hospital: 1 ☐ Inpatio		ER/Outpatier			4 Li Nui	rsing Hor			Other (Specif	y)	
ding F	lo no	27. Manner of Death 1. Natural 5 □ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	M	28c. Injun Wor	yat k? Yes 2∐N		28d, Describe	now injury	occurred		
death death the	Cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of In	iury - At ho	ome farm str			165 2		28f Location /	Street and	Vumber or Rura	I Route Num	her
Tin by	Certification;	4 Homicide determined	building, et	c. (Specif	y)	eet, lactor	y, onice			City or To	wn, State)	10111001 01 11011	a / 10016 / 40///	Dor,
spite nours norai		29a. Certifier 12 Certifying Phy	sician: To the best	of my kno	wledge, deatl	h occurred	at the tin	ne, date and	d place, a	and due to the	cause(s) a	nd manner as s	tated.	
To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificete he completely filled in by the funeral director, page	Medical	(Check only 2 Medical Exami	ner: On the basis of and manner st	of examina	tion and/or in	vestigation	, in my o	pinion, deat	th occurre	ed at the time,	date and p	ace, and due to	the cause(s	i)
To t withi To th	Z	29b. Signature and title of certifier	~	/_		29	c. Licens	e-number	1	,	29d. Date	signed (Month,	Day, Year)	1
		1///		-			W	15/	53	7	Ap	1121	100	6
10		30. Name and address of person who co	ompleted cause of	leath (tten	1 23а) (Туре,	Print)	06	7 1	/			L\	1 100	. [
10		31. Date filed (Month, Day, Year)	32. Registi	303	178	500	el (D 224	e,(3 Rn V) hapi	e, 141.	Mak	2
S Regis	tate	ADD 9 5 2006	Jz. Heyisti	ar a algita	Roger	20			9					

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Patricia 0907 AM Ann Patterson 22 Dri 2006 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore N/A Union Memorial Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 6, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2️F 212-36-5469 66 Yrs Director 1940 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Maryland N/A Baltimore 1XXYes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 3461 Chestnut Avenue 21211 USA death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iter any injury or other traumatic avant, the Medical Exactinat Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: ģ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Myrtle Irene Buchman Herman Charles Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3459 Chestnut Avenue Baltimore, Maryland 21211 Viola Herd Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 04/25/2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Juneral Service License ^{22. Name and Address of Faculty}
Burgee-Henss-Seitz Funeral Home, Inc. 21211
3631 Falls Road, Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** myorarded waxton /Medical Due to for as a consequence of): Examiner oronery arten f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed hi sections ion ettending physician and for use as the burial-tran Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetat death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the e Division of Vital Records, P.O. 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď cate has been sig page 2 should b 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. Director: / 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours after To the Funerei Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of enifie DOO 61310 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) afik Hanna 201 East University Parking MD 31. Date filed (Month, Day, Year) 32. Ragistrar's Signature State March)

Registrar

06-02682 Vincent Paige

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		ertificate	of Death		Reg	g No 2006	12814
Physici ledical Exam		Decedent's Name (First, Middle, Last)		-	_		Date of Death Month	Day Year	3 Time of Death 1333 hrs
neulcai Exam	illei	VINCENT PAIGE IR 4a. Facility Name (if not institution, give s	treet and number)		4b. City, Town, or Local		April 20, 20	4c. County of Death	
		Harbor Hospital Center	,		Baltimore			N/A	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs	s. last birthday)			8. Date of Birth	n(MM/DD/YYYY) 9. Bir Foreig	thplace (State or
Director		770 30 200 1	2 F 23	3	Yrs Months Days H	lours Min.	5-1-19	82	untry) MD.
y,		Usual Residence of Decedent 10a. State 10b. County	110c C	ity, Town or Lo	cation				40d Incide City Limite
I IOW AI				•					10d. Inside City Limits 1 X Yes 2 No
Maryland 28a-f show any d at once.	cto	MD N/A 10e. Street and Number		BALTIMO	RE 10f. Zip Code		100	g. Citizen of What Cou	
th the Maryland 23a or 28a-f sho notified at once.	Director	2519 SOUTHDENE A	VE.		21230			USA	,
with ms 23.	eral	11. Marital Status	2. Was Decedent Ever in		Was Decedent of Hispanic			14. Race - Amer	can Indian, Black,
r death or ite must	Funeral	1 Never Married 2 Married	Armed Forces? Yes 2 No		If Yes, specify Cuban, Mex		can, etc.)	White, etc.	
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5-0 iled w Hygie Jother the N	C	17. Father's Name (First, Middle, Last)				,		aiden Surname)	
21215-0036 hould be filed within 72 and Mental Hygiene. is marked other than vite event, the Medical	o Be	XINCENT PAIGE SR 19a. Informant's Name/Relationship (Typ		10h Mai		CHERYL			
ore, MD 21215-0036 so I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f she her traumatic event, the Medical Examiner must be notified at once	ř	CHERYL PAIGE (MOT			ling Address (Street and SOUTHDENE				
imore, MD 2 Pages 1 and 2 shoument of Health and Niant: If item 27 is nor or other traumatic		20a. Method of Disposition	20	b. Place of Disp	position (Name of cemeter)			20c. Location - City or	
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr		1 X Burial 2 Cremation 3 2 4 Donation 5 Other Specify:		crematory or	N CEMETERY	4-24-	-2006	BALTIMORE	MARYLAND
Baltimo permit. Page Department (Important: injury or otl	1	21. Schalure of Funcial Service License	JONATHAN D.	HIBNE	Name and Address of Fa	acility PHI	LIPS F	UNERAL HOM	P.A.
	y c	fautt (). His		1721-27 N. M				
Physician /Medical		23a. Parti. Enter the disease, or complice failure. List only one cause on each	itions that caused the dea line.	ath. Do not ente	er the mode of dying, such	as cardiac or re	espiratory arres	st, shock, or heart	Approximate Interval Between Onset and
xaminer			ultiple Gunshot Wo to (or as a consequence						Death
-		Sequentially list conditions, b.	o to (or as a consequence	C 01).					
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OD 00 00 00 00 00 00 00 00 00 00 00 00 00		23b. Was decedent pregnant in the	23c. If yes, outcome of pr		Fetal death 3 Ec	ctopic pregnanc	v	23d. Date of delivery Month	ay Year
Box 687 The death certifice the attending properties of the control of the astending properties of the control	hysicia		4 Pregnant at time of		Other (Specify)		,		a, roa
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Division of Vital Records, ral or Attending Physician: The law requints after death all Director: After this certificate has been sited in by the funeral director, page 2 should the formeral or the funeral director, page 2 should the formeral director, page 2 should the formeral director, page 2 should the formeral director, page 2 should the formeral director.	-1	27. Manner of Death	28a. Date of Injury (Month, Day Year) Apr 20, 2006	28b. Time	of Injury 28c. Injury at V		Bd. Describe ho	ow injury occurred	
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lospita hours unera	ပ	29a, Certifier	(Specify) Local Str					pelman Road, Ba	
Division of Vital Records, P.O. Box 68 within 24 hours after death certificate the remaining Physician: The law requires that the death certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	dical	one) 2 Medical Examiner: O	n the basis of examination		curred at the time, date and gation, in my opinion, deat				
T. w. i. v. i. o. o. o. o. o. o. o. o. o. o. o. o. o.	Medi	29b. Signature and title of certifier	d manner stated.		29c. License num	nber		29d Date signed (Mor	th, Day, Year)
		JUN9	1V		O.C.M.E.			April 21, 2006	
7		30. Name and address of person who cor							
O C		-	nt Medical Examin		enn Street, Baltimor	e, MD 2120)1 —————		
S Regis	tate trar	31. Date filed (Month, Day Year) 5 20	32. Registrar's Sign	ature	108482				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death APRIL 21 Day 2006 Year **Physician** 9:55 P_{M} MARY C. PETRECCA /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE **ESSEX** RIVERVIEW NURSING HOME If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, Year) JAN: 15, 1917 Birthplace (State or Foreign Country) **Funeral** Months Hours Days 1 ☐ M 2 🗑 F 215-03-9587 89 Yrs MD. Director Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Iteme 23s or 28s-f ehow the Medical Examiner must be notified at 1 Yes 2 No **ESSEX** Director BALTIMORE MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21221 1 EASTERN BLVD. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: Completed by 3 Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12TH \end{array}$ College (1-4or 5+) OWN HOME HOMEMAKER permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 le marked other eny injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be THERESA EBERT MICHAEL FOERTSCH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1960 SUE CREEK DR., BALTIMORE, MARYLAND 21221 19a. Informant's Name/Relationship (Type, Print) BEVERLY BURGAMY/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SACRED HEART OF JESUS 4/25/06 BALTIMORE, MARYLAND 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 21. Signature of Funeral Service Licensee 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 23a. Part1. Enter the disease, or complications shock, or heart failure. Litt only the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Immediate Cause (Final disease or condition an dio Physician /Medical resulting in death) as a consequence of) myo cerdial injanch - 1-2 days Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of): the attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 5 Other (specify) 9 Unknown signed by to Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 Probably 4 → tinknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 wursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending м 1 ☐ Yes 2 ☐ No death. investigation 2 ☐ Accident in by the Director 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a pelii 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) b 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MALIKA WASEEM. 709, BASTERN SLVD, MiD 31. Date filed (Mooth Day, Year) APR 2 5 32 Registrar's Signature State 2006 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Amend Items#20a, b, c&22 Per FH C855 5/4/06 CC State of Maryland / Department of Health and Mental Hygiene Amend Item #5 Per Ana Bd4/29/16/16/2018 of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 2045 M 04 2006 Edward Robinson /Medical **Examiner** 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Maryland Correctional Washington HOGERSTUCE.

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Months, Dey, Year)

OF 1919 Hagerstown Institute 5. Social Security Number 579–27–2026 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** 1 M 2□F Yrs. **Director** unk MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28e-f ahow the Medical Examiner must be notified at 10d. Inside City Limits **Funeral Director** 1 ☐ Yes 2√2 No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18601 Roxbury Road filed within 72 hours after death 21746 IISA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 X No If Yes, Give 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by Specify: 3 Widowed 4 Divorced Year or Dates: black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 none none 18. Mother's Name (First, Middle, Maiden Sumame) other traumatic avant, Baltimore, Maryland 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fit thent of Health and Mental H tent: If Itam 27 is marked of Be William Henry Robinson Brenda Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Robinson/mother 4916 Nash St. NE #3 Washington, DC 20019 20a. Method of Disposition

Surial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Harmony Memorial Park 4-24-06 5 Department of important: if any injury or once. 4 □Donation 5 ☎Other (Specify) in state Landover, Maryland 21. Signature of Funeral Service Licensee 22Roll Misser Hace, N.E. State Anatomy Board 455 W. Baltimore Street Baltimore, MD 21201 Washington, D.C. 20019 Ronald S. Rone 1d S. Wade Wirector

State Anatomy Board 655 W Baltimore, MD 21201 Washington Shock or heart failure. List only one cause on each line. Wade Approximate Interval Between Immediate Cause (Final **Physician** Hepatic disease or condition resulting in death) Coma /Medical Due to (onas a consequence of): **Examiner** nd Stage Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner ed by the attending physician and detached for use as the burial-transit executed resulting in death) Last Due to (or s a consequence of): Box 68760, The law requires that the death certificate be Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, mmunod Ictenc Virus 1 ☐ Yes 2 🔀 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 🕱 No 1 ☐ Yes 2 ☐ No Division of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Nother (Specify) Prisor 1 Yes 2 No s after death.

I Director: After this id in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; or Attending 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 🗀 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funerel Di completely filled in To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 04/17/2006 D57537 - MD 30. Name and address of person who completed cause of death (Item, 23a) (Type, Print) Roxburg Rd, Hagerstown, MD 21746 2. Registrar's Signature. 31. Date filed (Month, Day, Year) State APR 2 1 2006 Registrar

06-02584

Please Type or Print in Black Indelible Ink Gary Reynolds State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day April 16, 2006 **Medical Examiner** Edward 1503 hrs 4a. Facility-Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death 803 St. Paul Street **Baltimore City** NIA 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or Months Days Foreign Director 213.88.6938 1 XM 2 F Country) MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d, Inside City Limits Baltimore MD Yes 2 No hours after death with the Maryland Director 10e. Street and Number 10g. Citizen of What Country? 21202 Funeral 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 2 Married Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married Yes Widowed Divorced Black Yes 2 No specify: Specify: \$ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 lent of Health and Mental Hygiene. Refinisher Baltimore, MD 21215-0036 arade item 27 is marked other i r traumatic event, the Me 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname Nick Jacqueline Reundds Be 19a. Informant's Name/Relationship (Type, Print) ၉ (Street and Number or Rural Route Number, Cit or Town, State, Zip Code) Reundds 2728 N. 13th Street Philadelphia DA 19133 mne 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State BaltimoreMD Department of Important: breenmount Donation 5 Other Specify: 22 Name and Address of Facility Vices Cycmation Services 5/5/13a Himore National Pike Balto. MD 21229 21. Signature of Funeral Service 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line Between Onset and /Medical a. Atherosclerotic Cardiovascular Disease Death Immediate Cause (Final disease ⊊xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical attending physician for use as the burial -UNPENDED AMENDED Records, P.O. Box 68760, IE EEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? this certificate Yes 2 ✔ No 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Other₄ Hospital: Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 1 V Yes Residence 6 V Other: Scene ို After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural To the Funeral Director: completely filled in by the Pending within 24 hours after death. 2 ___ Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

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State Registra

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

31. Date filed (Month, Day, Year)

Deputy Chief Medical Examiner

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

April 18, 2006

State of Maryland / Department of Health and Mental Hygienen 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 9:05 a. M Bernadine Louise 4 17 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 2621 Woodland Avenue Balto N/A If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthptace (State or Foreign Country) **Funeral** Hours 1□M 2XF Days Director Yrs. 227-26-5648 12-25-1914 Va Usual Residence of Decedent the Maryland 10b. County 10a State 10c. City, Town or Location Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, its Medical Examinar must be notified at 10d. Inside City Limits N/A Balto Director 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 2621 Woodland Avenue 21215 death USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Iter may injury or other traumatic event, Ite Medical Examir at agree. Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: Black 3

Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home 12th grade N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James W. Wilson Mary Louise Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clifton Carver - Grandson 2621 Woodland Avenue Balto, Md 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐ Removal from State 4-21-2006 4 ☐ Donation 5 ☐ Other (Specify) Green Lawn Memorial Chesapeake, Va 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March West F/H 4300 Wabash Avenue Balto, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Aspiration Preumania Bucks /Medical Due to (or as a consequence of) Examiner Severe End Stage Dements Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine To the Hospitel or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Dicibedes that initiated events attending physicien and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical evelorescub disease 3 martin IF FEMALE 23c. tf yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death ed by the a 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ tomilation, Dehydation 1 Yes 2 No 3 Probably 4 Junknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation ours after death. nerel Director: All filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Dire 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4118106 040371 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr Harrytaplan. 10 4000 OLD COURT RD BALTIMORE, MD 21208 31. Date filed (Month, Day, Year) APR 2 5 2006 32. Registrar's Signature Bulles State Registrar

State of Maryland / Department of Health and Mental Hygiene [] [] [1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 8.56PM MICHELLE 1747 ZOO RUSSELL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Multi Medical Center Baltimore lowson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 12.69. 104 9. Birthplace (State or Foreign Country) **Funeral** 216.54.2471 1 ☐ M 2 🕱 F 56 Director Yrs. MD Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show treumatic event, the Medical Examiner must be notified at MD Baltimore Completed by Funeral Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5703 Fenwick Aleme USA Items 23a it. Pages 1 and 2 should be filed within 72 hours after death riment of Heath and Mental Hygiene. Trient: If item 27 is marked other then "neturel; or Items 23 niury or other trematic event, the Medical Featurel multiplian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Correctional Dietany
Administrator 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry State of MD College (1-4or 5+) Elementary/Secondary (0-12) 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Grade Watkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Russell 5703 Fenwick Avenue Baltimore MD 21239 Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1

■ Burial 2 □ Cremation 3 □ Removal from State 04.24.00 Owings Mills, MD Garrison Forest ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Vaughn C. Greene Funeral Sewices 49.05 York Road Baltimore MD 21212 21. Signature Funeral Service Licensee Dep mpc any lem 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final aMETASTATIC Physician YEAR disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Due to (or all a punsequence of): Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospitel or Attending Physicien: The law requires that the death certificate be executed DIABETES MONTUS Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month 4 Pregnant at time of death Day 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate has autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1 Inpatient 2 ER/Outpatient 3 DOA 0 1 ☐ Yes 2 ☐ №6 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After 1_Hatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a e Funerel (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) APRIL 1850 2006 Spro de MD DO053150 30. Name and address of pers of who completed cause of death (Item 23a) (Type, Print) COUNBIA 9650, Senhego Road Stute 110 Shakunmale porte Registrar's Signature 31. Date filed (Month, Day, Year) APR 2 5 2006 State Registrar

			1 - For State Registrar	State of Maryla			nt of H	ealth an	d Mental H) U 6	12820
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	ter de	Į,		12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Deced If Yes, spe-	dent of His	spanic Origin' n, Mexican, P	? (Specify Yes or luerto Rican, etc.)	No- 14. I	Race - Americ Black, White,	an Indian, etc.
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<u>~</u>	should Ind Men	-	19a. Informant's Name/Relationship (Typ	pe, Print)	19b. Mailir	na Address	(Street a		Rural Route Num		wn State Zio	Code
	and 2 salth a n 27 is		Mrs. Carol Boyette	/ Daughter					t, Odent			
ē,	s 1 a f Hea ftem othe		20a. Method of Disposition	206	. Place of Dispo cemetery, crer			- T	Date		on - City or To	
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. I mimportant: If term 27 is marked other than "natural; or items 23a or 28a-f show any Injury or other traumatic event, the Madical Examiner must be notified at ances.		21. Signature of Funeral Service License						006	Gambr	ills,	Maryland
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DHMH 17 Rev 1/2001

State Registrar Charles St BAZAMOSE ND 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature.

AARON CHARLES, MD

31. Date filed (Month, Day, Year)

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			Registrar 1. Decedent's Name (First, Middle, Last)			itilicate of t	Jeani	2. Date of Dea	eg. No.	3. Time of Death
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	and 2 salth a n 27 ls		James W. Reed - husl	oand	600	Light Str	reet #724	4, Baltim	ore, MD	21230
ore	of He of He if Item		20a. Method of Disposition 1 ☐ Burial 2 💆 Cremation 3 ☐ Remail	oval from State	Ob. Place of Dispo cemetery, crei	osition (Name of matory or other place	9)	Date	20c. Location - City of	or Town, State
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Division of Vital	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 2	Be. Place of Injury - building, etc. (S	At home, farm, str pecify)	eet, factory, office		28f. Location (Sti City or Town	reet and Number or F i, State)	Rural Route Number,
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			+ Bonatun WI	Lown	MIL	DI	550	5 F	tpril 2	42006
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	Q,		1. Decedent's Name (First, Middle, Last						2. Date of	Death		3. Time of Death
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	Exami		4a. Facility Name (If not institution, give	street and number	er)		Town, or	Location of D			c. County of Death	
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	Director		231-09-8897 Usual Residence of Decedent		O J TIS	•			Nov.	29,	1936	Virginia
	/land		10a. State 10b. County		10c. City, Town o	r Location						10d. Inside City Limits
	vith the Maryland or 28a-f show	to	MD N/A		Baltim	ore						1 y Yes 2 □ No
	n the	Directo	10e. Street and Number		Darein	10f. Zip	Code			10g. C	Citizen of What Cou	intry?
	death with the Maryland ms 23a or 28a-f show r must be matified at	al D	2030 E. North	Ave.		21	213			т.	J.S.A.	•
		Funeral	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U.S.			spanic Origin	? (Specify Yes or uerto Rican, etc.)	No-	14. Race - Amer	
98	g 9 E		1 Never Married 2 Married	1 ☐ Yes 2√ If Yes, Give	No	1 ☐ Yes			uerto Hican, etc.,		Black, White Specify: Bla	
21215-0036	hours after tural', or Ita	d by	3 Widowed 4 Divorced	Year or Dates	s:						Specify: D 1 d	CK
5	n 72 ho "natur	Completed	15. Decedent's Edu (Specify only highest grad	ication le co <i>mpleted)</i>	16a. De	ive kind of wo	al Occupa	ation furing most of)	working	16b.	Kind of Business/Ir	ndustry
12	withir ane. than	E G	Elementary/Secondary (0-12)	College (1-40	or 5+)							
	filed Hygi hygi ant, I	ပိ	8th 17. Father's Name (First, Middle, Last)			Dis	able		Name (First, Mia	dle Maide	N/A	
an	ld be ental ked c	To B	Elgie Robe	rtson					berta			
Maryland	2 should be filed within 72 hours and Mental Hygiene. Is marked other than "natural", aumatic avant, the Medical Exa	-	19a. Informant's Name/Relationship (Ty		19b. M	ailing Address	(Street a				nney or Town, State, Zij	Code)
	ges 1 and 2 should be filed within to the Health and Mental Hygiene. If item 27 is marked other than or other traumatic avant, Ire Mental trau	1	Anthony McNai:	r/ Neph							Md 2121	
ore,	es 1 a of Hei fitam rothe	1 3	20a. Method of Disposition	-	20b. Place of Di	sposition (Nar crematory or o	me of		Date	20c.	Location - City or T	own, State
Ĕ	Page nent c int: If		1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		Mt. Zi	-			rill9.	2006	Balto.	MD
Baltimore,	permit. Pages 1 and Department of Health Important: If itam 27 any injury or othar tr once.		21. Signature of Funeral Service Logics			22. Name an	nd Addres	s of Facility				
<u>m</u>	8 3 E 8 8		COLD	-01	Δ	CAL 14	У1N 12 Е	B. SC	RUGGS STON S	FUNE	RAL HOM ALTO. M	E D 21213
П			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caus	ed the deam. Do not ine.	enter the mod	le of dying	, such as care	diac or respirator	y arrest,		Approximate Interval Between
	Physician	e 14	Immediate Cause (Final disease or condition MYOCARDIAL INFARCTION Onset and Death									
H	/Medical Examiner		resulting in death)		as a consequence of):							[1100/F=
Н	LAGITITIES	3-m	Sequentially list conditions,	o. =								
	ed sit	lne	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or a	as a consequence of):							
	be executed iiclan and burial-transit	Examiner	that initiated events resulting in death) Last		as a consequence of):							
8760,	eath certificate be executed attending physician and for use as the burial-transit											
687	ificate g phy as the	Physician/Medical		J								
Вох	nding use a	M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcom	ne of pregnancy						23d. Date of delive	arv.
	death e atte	icia	in the past 12 months? 1 □ Yes 2 ☑ No	4☐Pregnant	at time of death	3 □Ectopic pr 5 □ Other <i>(sp</i>					Month	Day Year
P.0	that the ded by the detached	hys	9 Unknown	9□ Unknown								
	The law requires that the death certific Ite has been signed by the attending p page 2 should be detached for use as	by F	Part II. Other significant conditions cor	ntributing to death	but not resulting in the	underlying c	ause give	n in Part I.	23e. Di	d tobacco	use contribute to the	ne cause of death?
ord	w requir been si should								_ 11	☐ Yes 2	2 No 3 Prot	ably 4 Unknown
Vital Records,	e law r has be ge 2 sh	Completed							24a. W	as an	24b. Were auto	psy findings available impletion of cause of
- R		Con								rformed?	death?	2₽ No
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?						Death (Check on	v one)		Λ
of	Physical this of all directions and directions and directions and directions are all directions and directions are all directio	2	1 162 5 1140		tient ZECVOutpat		Othe	r: 4 🗆 Nursin	g Home XXR	sidence	6 ☐Other (Specif	y)
L	ding h. After funer	on	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of In (Month, D	jury 28b. Time Jay Year) Injur		8c. Injury Work		28d. Describ	e how inju	ury occurred	
Si	ttendi death. ctor: A / the fu	ical	2 Accident investigation 3 Suicide 6 Could not be	28e Place of I	njury - At home, farm,	M stroot factors		es 2□No	20f Location	/Ctrant	and Morabas as Door	/ O
Division	I or Attend after death Diractor: ,	Certification;	4 ☐ Homicide determined	building,	etc. (Specify)	street, lactory	, onice		City or	Town, Stat	ind Number or Rura (e)	I Houle Number,
	pours ours naral filled		29a. Certifier 1 Certifying Phys	sician: To the bes	st of my knowledge, de	ath occurred :	at the time	date and pla	ace, and due to ti	ne cause/s	s) and manner as el	atod
	e Ho 24 h a Fur	edical	(Check only 2 Medical Examinations)	ner: On the basis and manner s	of examination and/or	investigation,	in my op	inion, death or	ccurred at the tim	e, date an	nd place, and due to	the cause(s)
	To the Hos within 24 h To tha Fun completely	Me	29b. Signature and title of certifier			29c	. License	number		29d. Da	ate signed (Month,	Day, Year)
	1		Ruid	MD		1	ZE	5-00	0	Apr	(il 17,	2006
	(2)		30. Name and address of person who co	mpleted cause of	death (Item 23a) (Typ	e. Print)						
			Robin Veidt Johns	Hopkin	is Hospital	Balt	imo	re, N	larylan	d 2	1287	
*	Sta Registr	te	31. Date filed (Month, Day, Year) APR 2 5 2006	32. Regis	trar's Signature	1		,				

			1 - State of Maryland / Dep	partment of Health and Nertificate of Death		ene 2006	12824				
ė	Physic /Medi		1. Decedent's Name (First, Middle, Last) Albert G. Reed, Sr.		2. Date of Death		3. Time of Death 4:28 P M				
200	Examir		4a. Facility Name (If not institution, give street and number) 2525 Pot Spring Road Apt. S519	4b. City, Town, or Location of Death	1	4c. County of Death Baltimore					
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 1		Jan. 22,	1929 Mary	place (State or Foreign				
21215-0036	he Maryland 28a-f ehow	ector	MD Baltimore 10c. City, Town or to Timonium				10d. Inside City Limits 1 ☐ Yes 2 🏋 No				
	23a or 2	Funeral Director	2525 Pot Spring Road Apt. S519	10f. Zip Code 21093	10	g. Citizen of What Cou USA	intry?				
	within 72 hours after death with the Maryland ene. than "naturel", or items 23a or 28a-f ehow he Madical Exemitier night be notified at	by	1 Never Married 2 Married 1 Ty Yes 2 No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	Decify Yes or No- Decify Yes o	14. Race - Amer Black, White Specify:					
	ed within 72 h giene. er than "natu i, ine Madical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self	redent's Usual Occupation re kind of work done during most of work DO NOT use retired) Employed	king	b. Kind of Business/Industry Ontractor					
/land	uld be file Mental Hy irked oth	To Be (17. Father's Name (First, Middle, Last) Frederick P. Reed	18. Mother's Nam Isabelle	e (First, Middle, Ma Scott	,					
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or items 23a or 28a-1 show any injury or other traumatic event, the Madical Examinar must be notified at once.		Norma L. Reed / wife 2525 20a. Method of Disposition 1		Apt. S519 /06 S		n, MD 21093 own, State				
8760,	The law requires that the death certificate be executed Medical Ale has been signed by the attending physicien and Dage 2 should be detached for use as the burial-transit United Statement Stat	dical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Approximate Interval Between Conset and Death Condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								
O. Box 6	the death certific y the attending p Iched for use as	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year					
rds, P.	quires that the de n signed by the a uld be detached t	by	Part II. Other significant conditions contributing to death but not resulting in the tight of the significant conditions contributing to death but not resulting in the tight.	cco use contribute to the cause of death?							
al Records,		Completed	Coronary Artery Disease 24a. Was an autopsy performed? 1 yes 2 No 1 yes 2								
Division of Vital	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director.	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ce 6 □Other (<i>Specify</i>) injury occurred							
DIVIS	rs after de el Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Ptace of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rura State)	al Route Number,				
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deat of my knowledge,	rvestigation, in my opinion, death occurr	red at the time, date	and place, and due to	the cause(s)				
	D W T	-	29b. Signature and title of certifier William and address of passon who completed exuse of death (for one) Trans	29c. License number MD D421c Print) O i N. Charles		Date signed (Month,					
-	10+1		30. Name and address of person who completed cause of death (ftem 23a) (Type, William D. M. Connell (3) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	of N. Charles	57. B	altmu	و ١١١٥				
1	Sta Registra		APR 2 5 2006	posto)							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year 250 Am KO 550 SavaH april ZW /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore
f Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Good Samaritan Nursing Center 7. Age (In yrs. last birthday) **Funeral** Birthplece (State or Foreign Country) 1 □ M 2XXF Months Director 276-05-3706 93 03-17-1913 Ohio Usuel Residence of Decedent 10a. State 10b. County 10c, City, Town or Location item 27 is marked other than "natural", or Items 23a or 28e-f show other trsumatic event, the Madical Examinar must be notified at 10d. Inside City Limits 1 X Yes 2 ☐ No MD Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1651 E. Belvedere Avenue U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※XXNo If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 ģ White Specify: 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Examiner 11th Clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental Importent: If item 27 is marked or any injury or other trsumatic eva once. Pages 1 and 2 should be John Rosso Frances Rosso 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Rosso/ Son 20b. Place of Disposition (Name of cometery, crematory or other place)

Catonsville, Np. 21228

Date 20c. Location - City or Town, State Baltimore, 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 04-25-06 _Baltimore, MD perniit. 21. Signature of Fanera Service Cicensee 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc 6415 Belair Road, Baltimore, MD Lyma 21206 28a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Congestive heart failure **Physician** disease or condition /Medical resulting in death) **Examiner** Stenosis lornic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed use as the burial-tran and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ρ Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. | detached the 9 Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed Deen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Yes 2t 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: Mursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Peath 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely fitled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check on one) and manner stated. 29b. Sign ure and title of certifier D46504 30. Name and address di person who completed cause of dear (Item 23a) (Type, Print) 5601 Loch Raven Blvd, Baltimore, MD Nancy Friedley, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 25 2006 Registrar

			For State Registrar	State of Marylar	•	nt of Health and te of Death		iene 2006	12826
			Decedent's Name (First, Middle, Last)		00111100		2. Date of Deat	h	3. Time of Death
	Physici		MAR	14	STREE	T	APRIL	Day Year 23 2006	8:35 AM
1	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		Town, or Location of Deat		4c. County of Death	1 0
	LAGITIT	٠.	NORT	HWEST HOS	PITAL	RANDALL	STOWN	BA	LTIMORE
	Funeral		Social Security Number 6. Sex			r 1 Year If Under 24 Hrs	B Date of Birth	9. Birth	place (State or Foreign.
	Director		212-58-3250 10	M 200 F 54	Yrs. Months	Days Hours Min.	ALIGITA	3/95/ NO	aruland
	p ,		Usual Residence of Decedent	10- 0	T				
	aryla shov	5	10a. State 10b. County	ioc. Cii	ly, Town or Location	() () () ()			10d. Inside City Limits 1 Yes 2 No
	89-f	Director	Maryland Dall	more	VVUUAII	awn			
	with t		10e. Street and Number	00 00-11	\mathcal{D}_{J}	Code	10	Og. Citizen of What Cou	intry?
	s 23	Funeral	1034 Winas	12. Was Decedent Ever in U	S 12 Was Dow	CIAD/	Specify Ves or No	14. Race - Amer	/†
	ter d	un-	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Amed Forces?	If Yes, spi	dent of Hispanic Origin? (S scify Cuban, Mexican, Puer	to Rican, etc.)	Black, White	
38	urs at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes	2 No Specify:		Specify:	ack
Ď	be filed within 72 hours after death with the Maryland at Hygiene. A death Hygiene. A death than "natural", or items 23a or 28e-f show other than "natural", or items 23a or 28e-f show event, the Modical Examination must be notified at	Completed	15. Decedent's Educ		16a. Decedent's Usi	al Occupation	4	16b. Kind of Business/li	ndustry
21	thin 7	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT	ork done during most of wo use retired)	rxing	n // 1	
7	filed with Hygiene. other that	Con	9	0	DIS	abled		NIA	
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yla	2 should be filed within 72 hours after death with the Marylan and Mental Hygiens and Mental Hygiens is marked other than "natural", or items 23a or 28e-f show aumatic event, tra Modical Examinat must be notified at	우	Mongue 1	litchell		Dor	15 6	ault	
Maryland 21215-0036	2 sho		19a. Informant's Wame/Relationship (Ty)	De, Print) (Husband)	19b. Mailing Addres	s (Street and Number or R	ural Route Number,	City or Town, State, Zi	p Code)
	ges 1 and 2 should at of Health and Mer if Item 27 ia marke or other traumatic		20a. Method of Disposition	· Sireet	Place of Disposition (Na	Wechen :	Date 2	20c. Location - City or T	and di
סַר	00		1 ⊠ Burial 2 □ Cremation 3 □R	emoval from State	cemetery, crematory or	other place)	12006 1	Location - City of 1	1:1/ M /
Baltimore,	permit. Peges Depertment of Important: If i any injury or once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	160		TOTEST	12000	wings 1	IIIS, Mai
B	permit. Peg Depertment Important: i any injury o once.		Mohh	L. BUN	1/ Josep	L. Russ	Funera	1 Home, P	A.,
			23a. Part 7. Enter the disease, or complished or heart failure. List only on	callons that caused the deat	h. Do not enter the mo	de of dying, such as cardia	c or respiratory arre	est, NIA. 21	Approximate Interval Between
	Physician		tmmediate Cause (Final	1 - 1					Interval Between Onset and Death
)	/Medical		disease or condition resulting in death)	Due to (or as a conseq	LEROTIC Juence of):	CARDIOVAS	2 V WAC	DISEATE	
	Examiner		Sequentially list conditions						
	D ::	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):				
	and -trens	каш	that initiated events resulting in death) Last	Due to (or as a conseq	ulence of				
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687	ficate physics the	edical	d						
Вох	leath certific attending p	N/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna				23d. Date of deliv	rerv
Ď	death e atte d for	Ca	in the past 12 months? 1 □ Yes 2 2 No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d				Month	Day Year
o.	at the by th tache	Physician/Me	9 Unknown	9□ Unknown					
s,	res that the de signed by the a be detached f	by	Part II. Other significent conditions con	tributing to death but not res	ulting in the underlying	cause given in Part I.		acco use contribute lo	11
ord	w requir been si should l	ted					1 ∐ Ye	s 2 No 3 Pro	bably 4 Unknown
Records,	law esb e2st	Completed					24a. Was ar autopsy	prior to co	opsy findings available empletion of cause of
E	: The lav	ဝိ					perform 1 ☐ Yes 2	ned? death? No 1 ☐ Yes	2×100
Vital	icien: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	ospital:		Other	ath (Check only one		
ō	Phys this ral dii	6	1 Yes 2 No	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatient 3 D	UA 4 Nursing F	fome 5 Reside	nce 6 Other (Speci	fy)
0	After fune	tlon	1 Natural 5 Pending 2 Accident Investigation	(Month, Day Year)	Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	200. 20001120 110	w many occurred	
Division of	Atten deal octor	flca	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At he building, etc. (Specif				eet and Number or Rur	al Route Number,
	s effe in Dire	Certification;	4 Homicide	building, etc. (Specif	y)		City or Town	, State)	
	lospii uner uner		29a. Certifier Sertifying Phys	ician: To the best of my knower: On the basis of examina	owledge, death occurred	at the time, date and place	e, and due to the ca	use(s) and manner as	stated.
	To the Hospitel or Attending Physicien: within 24 hours elfer death as the forming to the Funeral Director. After this certified completely filled in by the funeral director.	Medical	one)	and manner stated.		c. License number			
	¥ ₹ ¥ §		29b. Signature and title of certifier	Kottala N	1)	D 43481		APA i(a 2 2	
	Λ		30. Name and address of person who co	moleted cause of feath (1	n 22a) (Tuna Briat)	D 10101		APRIC 23	
	d		MILLEL ROTHE	mpleted cause of death (Item	OUD COUL	ET ROAD	RANDAUS	JOWN MAR	4 CAND 21133
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa			, v 1W,		1
36	Registr	ar	APR 2 5 2006	the service	150000C				

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** James S. Scalio 2:00 P.M Apri1 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Pine Hill Assisted Living Laure1 Howard 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 20, 1 9. Birthplace (State or Foreign Country)
Maryland **Funeral** Days Months Hours 1 ☑ M 2 ☐ F 73 Jan. 213 28 5241 Director 1933 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "naturel", or Items 23a or 28e-f ehow 10a State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23s or 28e-f ebov other treumstic event, the Modical Examinar must be notified at 1 ☐ Yes 2 € No Maryland Directo Howard Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8455 Murphy Road 20723 U.S. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 2 Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Computer repairman Computer Company vear 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Myrtle Miles Samuel Scalio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christy Markham / sister 604 Lancelot Lane Bel Air, Maryland 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1 Department of H Important: If ite eny Injury or ot once. 1 Burial 2 Cremation 3 Removal from State Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park 4/24/2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore, Maryland 21225 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician END PARKINSON'S DISEASE STAGE GENNS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ettending physicien for use as the buria by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9 Unknown 9 Hunknown ል Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed 2 ☐No 3 ☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificete 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient ASTITUTED LIVING Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 6 Rour 14046 1 ☐ Yes 2 ☐ No P 2 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident efter death Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide hours 6 Funerel Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ţ ş 29c. License number 29b. Signature 2 DS1860 address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and PISH JONATH 45 10700 CHARTER DRIVE \$ 200 COLUMBIA MO 21044 31. Date filed (Month, Day, Year) 32. Aegistrar's Signature State Registrar 2006

			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of H rtificate of L			giene	12828
	Physici /Medi		Decedent's Name (First, Middle, La B)		EIHL ST	UDY		2. Date of Dea Month APRIL	Day Ye 20. 200	3.4
k —	Examir Funeral		4a. Facility Name (If not institution, given GOLDEN CREST 15. Social Security Number 6.5	ASSISTED	LIVING (In yrs. last birthday)	4b. City, Town, or HAMPS If Under 1 Year		h 8. Date of Birth	4c. County of E	Death
	Director	1	216-10-0330 Usual Residence of Decedent	I□M 2½TF	90 Yrs.	Months Days	Hours Min.	(Month, Day 3 / 1 5 /	r, Year)	Country) ARYLAND
	death with the Maryland ms 23a or 28a-f ehow r rust be notified at	tor	10a. State 10b. County MD CARROL	L	10c. City, Town or Le WESTM					10d. Inside City Limits 1 ☐ Yes 2 X No
	h with the 23a or 28	ai Director	10e. Street and Number 612 DEER PARK	RD.		10f. Zip Code 21157		1	10g. Citizen of What	Country?
036		by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 No. If Yes, Give Year or Dates:	0	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 No	spanic Origin? (S n, Mexican, Puen Specify:	pecify Yes or No- to Rican, etc.)		merican Indian, /hite, etc. /HITE
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Baltimore,	Page ent o nt: if 'y or		1 Donation 5 Other (Specification 2)	y) G	cemetery, createry	matory or other place CEMETER	RY 4/24	1/06	20c. Location - City	N, MD
g B	permit. Popartm Departm Importar eny injui		23a. Part I. Enter the disease, or com		25	Name and Address	IN ST.,	WESTMIN	NSTER, M	D 21157
	Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	consequence of):	Brens			est,	Approximate Interval Between Onset and Death
08/pn,	certificate be executed XX ding physicien and XX use as the buriat-transit a	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter the straight of the cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):					
. DOX	ath certi	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₺No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
cords, r	w requires that the de been signed by the should be detached	5	Part II. Other significant conditions c	ontributing to death but	not resulting in the u	nderlying cause giver	n in Part I.			to the cause of death? Probably 4 Unknown
	n: The law re ficete hes be or, page 2 sho	e Completed	Of Warrand and American				40-		y prior death	autopsy findings available to completion of cause of ?
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	7		30. Name and address of person who	Double completed cause of dea	th (Item 23a) (Type	Print)	544	3	4/21/2	266
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State of Maryland / Department of Health and Mental F

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Hygiene 06	12829

			1 = State Registrar	Certificate of Death		Reg.	ZUUD No.	12829
	Dhyolei	*	Decedent's Name (First, Middle, Last)		2. Da	ate of Death	Day Year	3. Time of Death
	Physici /Medic		Dorothy Ann Stronsky			il 22,	2006	5:30 A M
	Examir	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of E	Death		4c. County of Deal	
*	a. <u> </u>		Manor Care Nursing Home-Rossville 5. Social Security Number 6. Sex 7. Age (In yrs. last bin		4 Hrs. 8 Da	ate of Birth	Baltin	
	Funeral Director		4 D M OFFE		Min. Ap.	ate of Birth Nonth, Day, Ye ril 13	,1925 Mo	thplace (State or Foreign buntry) ULYLand
	nyland how		10a. State 10b. County 10c. City, Town	or Location	-			10d. Inside City Limits
	Ba-f •	cto	Maryland Baltimore	Middle River	۲			1 ☐ Yes 2X No
	with th	Director	10e. Street and Number 6942 Gunder Avenue	10f. Zip Code 21220		10g.	Citizen of What Co	ountry?
	ns 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.		in? (Specify Y	es or No-	U.S.A.	eńcan Indian.
020	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23s or 28s-f ehow other traumatic event, the Madical Examinating Landillad at	by	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, 2 No If Yes, 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	Puerto Rican,	, etc.)	Black, Whit	
ה ה	72 ho	Completed	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most or	of working	16b	. Kind of Business/	Industry
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a	should and Men s marke umatic	-	19a. Informant's Name/Relationship (Type, Print) 19b.	Mailing Address (Street and Number of	or Rural Rout	te Number, Cit	y or Town, State, 2	Zip Code)
2	and 2 saith a n 27 is			942 Gunder Avenue,		le Rive	er, MD 2	1220
ב כ	Pages 1 nent of He int: If Iten iry or oth		1 Burial 2 Cremation 3 Removal from State	Disposition (Name of y, crematory or other place)	Date		. Location - City or	
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Ö	permit. Pages 'Department of the Important: If Ite eny Injury or ot once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility 99705 Belair Rd.				
i.			23a. Part1. Enter the disease, or complications that caused the death. Do n				MU ZIZS	Approximate
	Physician		shock, or heart failure. List only one cause on each line.	Plann	1:			Interval Between Onset and Death
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000	ertificate be executed ing physician and e as the burial-transit	Medical	d					
C. DOX	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of del Month	ivery Day Year
ŗ	s that	by Ph	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	2:	3e. Did tobacc	o use contribute to	the cause of death?
COLOS,	quire an sig	ed b				Yes	2 □ No 3 □ Pr	obably 4 Dunknown
מטפר	The taw re te has bee	Completed			_	4a. Was an autopsy performed ☐ Yes 2 💢	? death?	itopsy findings available completion of cause of
<u> </u>	entifica ector, p	Be	25. Was case referred to medical examiner?	26. Place of	of Death (Che			
5	hysia this ca	၉	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Out				6 ☐ Other (Spec	cify)
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	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and manner stated.	death occurred at the time, date and p	place, and du occurred at ti	e to the cause he time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	To the To the Comp	Ž	29b. Signature and Me of certifier	29c. License number		29d. I	Date signed (Monti	h, Day, Year)
	5		1111h	19454	75		1124/	0
			30. Name and address of person who completed cause of death (Item 23a) (Dr. M. R. Rahnama, 9512 Harford Ro		timore.	MD 21	234	
1	Sta Registr		31. Date filed (Month, Day, Year) APR 2 5 2006 32. Redistrar's Signature	Sparker				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** April 2006 7:05 P Robert William Stoute /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Catonsville 801 Hilltop Avenue 8. Date of Birth (Month, Day, Year)

Jan. 31, 1922 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Hours Days Yrs. Pennsylvania Director 180-16-5806 84 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a Slate 10b. County ral', or items 23a or 28a-f show Examiner must be nutilized at 1 Yes 2 No Director Catonsville Maryland Baltimore 10f. Zip Code 10g. Cilizen of What Country? 10e. Street and Number 21228 и. S. A. 801 Hilltop Avenue Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 Is marked other them "matural" or hear 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: þ White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4or 5+) Machinist Manufacturing 12th Grade 18 Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Frank Stoute Alice Warner 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 801 Hilltop Avenue, Baltimore, Maryland 21228 Mark Stoute 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 04/25/2006 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 21. Signature of Funeral Service Coensee 22. Name and Address of Facility Schimunek Funeral Home Inc. Š Duren 3331 Brehms Lane, Battimore, Maryland 21213 Jecino 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediale Cause (Final Physician LEUKEMIA disease or condition LYMPHATIC resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a nonsequence of): Examiner the attending physician and thed for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has 1□ Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After Injury 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident completely filled in by the I Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MRIL 24 D01786 Laurence Gallager, My 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maiden Choice Lane Laurence Gallager MD 716

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 2 5 2006

32. pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Ragistrar	State of Ma		partment of Healertificate of De		ntai Hygien Rag. N	000	12831
	Physici /Medi		1. Decedent's Name (First, Middle, Las	J. Sa	1 ZONG		F	Date of Death Month Da	2006	
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	h the Mau r 28a-f sl	Director	MD HARFO	20	tore	25+ H11		10g. C	itizen of What Co	1 Tes 2 No
	death wit	Funeral D	1710 Landmar	12. Was Decedent Ev	pt, L. ver in U.S. 1	3. Was Decedent of Hispa If Yes, specify Cuban, I		y Yes or No-	USA- 14. Race - Amer	rican Indian,
9000	72 hours after death with the Maryland natural', or Items 23a or 28a-f show Jical Exattal or must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:			Mexican, Puerto Ric	an, etc.)	Specify: LC	hite.
21215-0036	within 72 t ene. than "natu	Completed	15. Decedent's Ed (Specify only highest gra		(G	cedent's Usuat Occupation ive kind of work done during to NOT use retired	on ing most of working		Kind of Business/I	Station
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, Maryland	riit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan adment of Health and Mental Hygiene. ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Examination in the molitied atm.	-	19a. Informant's Name/Relationship (7			ailing Address (Street and	110	Poute Number, City	or Town, State, Z	ip Code) 40 21081/
Baltimore	permit. Pages 1 Department of He Important: If Iten any injury or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 1 □ Donation 5 □ Other (Specify		20b. Place of Discemetery, of	sposition (Name of prematory or other place)	1-BelAir 4	/21/04 F	ocation - City or T	11/110
Bal	permit. Pag Department Important: any injury o		21. Signature of Fungral Service Licen	as the	ŧ	22. Name and Add ss o	OCho sel	Baldin -	0 21055 3 Veripo	ort De.
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Division of Vital Records, P.O. Box	Attending Physician: The law requires that the death certificate be executed ir death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of deliv Month	very Day Year
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Divis	ital or Atters after de al Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, (Specify)	street, factory, office	28f.	Location (Street ar City or Town, State	nd Number or Rur 9)	al Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director; After this certificate has completely filled in by the funeral director, page 2	Medical	one)	ysician: To the best of ninar: On the basis of e and manner state	xamination and/or	ath occurred at the time, of investigation, in my opinion	on, death occurred a	at the time, date and	d place, and due t	to the cause(s)
)	-	<	29b. Signature and title of certifier Brolhad a	2. Elytt	L-MO	29c. License nu			ZI/06	
	10		30. Name and address of person who dead to the second seco	ompleted care of dea . EBR16H7	th (Item 23a) (Typ	e, Print) 4 Belair K	Rd BALT	, MD 2	1236	
	Sta Registr	.01	30. Name and address of person who concentrated the service of the	32. Registrar	s Signature	edi	•			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#21,perFH, 2854, 4/25 06 TT Copies are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year 入りのサン Physician D' CO AM 2006 Joseph Spalt /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 7,1927 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **X**☐M 2☐F 220-22-7944 79 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Be Completed by Funeral Director Anne Arundel Pasadena 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7796 Fox Court 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If ₩es, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore Gas and Elementary/Secondary (0-12) 12 College (1-4or 5+) Crane Operator Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Walter Spalt Mary Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MrsJoann E. Hoffman / Daughter 105 Mall Road GLen Burnie, Maryland 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State April 26, Mandamidaa Mam

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death Division of Vital Records, P.O. Box 68760,

Funeral

Director

				10c. City, Tow	vn or Location					10d. Inside City Lim
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Director	e L	10e. Street and Number		1 404		ip Code	<u>.</u>	10a. Citi	zen of What Co	21
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Suce		21. Signature of Funeral Service Lice				and Address of Facility	_			Home, P.A.
s 01	4	Donna M. Dallas I				nd Avenue			D 21061	
		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	y one cause on each li	ne.	6	ode of dying, such as ca	ardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
ian cal		Immediate Cause (Final disease or condition resulting in death)	a pr	Enm	MIA	•				
ner		1	Due to for as	a consequence	of):	9 0	2066			
<u>.</u>	_ G	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequen	of):	in dis-	0		_	
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			For 1 - State Registrar	State	of Marylar		ent of Health a ate of Death		ntal Hygiene Reg. No	711116	12833
	Physici	an	Decedent's Name (First, Middle)	le, Last)	CLIA	14007		2.	Date of Death Month Day	y Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution	give street and		NHART	ity, Town or Location	of Death	4 2 40.	County of Deatl	
•	Lxamiii	IC1	BALTIMORE	WASHIN	SION C	Inter	Glan /	Bufr	rie,	ANNE	Arunsel
	Funeral Director		5. Social Security Number 215302707 Usual Residence of Decedent	6. Sex 1 ☐ M 2 🖸	7. Age (In yrs.	72 Yrs. Mont	hs Days Hours	Min. 8.	Date of Birth (Month, Day, Year)	9. Birth	hplace (State or Foreign untry) C
	yland 10W		10a. State 10b. Count	,	10c. Ci	ity, Town or Location					10d. Inside City Limits
	deeth with the Maryland me 23a or 28a-f ehow rinust be notified at	ctor	MD Anne	Arunde1		Glen Burn	ie				1 ☐ Yes 2 🖾 No
	with th	Funeral Director	10e. Street and Number			1	Zip Code 061		10g. Cit	izen of What Co	untry?
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) Ja		To	Jeffrey Briggs					a Hutc			
ă Z	d 2 should th and Mer t7 ie marke traumatic		19a. Informant's Name/Relation Mr. Thomas Swa		r. / son		k Drive; P		-		(ip Code)
ē,	s 1 and 1 Heal		20a. Method of Disposition		20b.	Place of Disposition (cemetery, crematory		Date		ocation - City or	Town, State
Ē	Pages ment of ant: if i ury or		1XXBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (lem. Park	4-25-2	2006 Gler	n Burnie	, MD
ď	Sermit. Separti mporti nny inj		21. Signature of Funeral Service	Licensee			and Address of Facili	_			
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	uted 1 Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<	NoTo) cooles	100 A	ctus	la		2 Westi
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Ē	The ete h page	Com							autopsy performed? 1☐ Yes 2☑ No	death?	
VII a	Attending Physician: 7 r death. sctor: After this certificel by the funeral director, p	Be	25. Was case referred to medic examiner?	Hospital			Other		check only one)		
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	To the within To the	Me	29b. Signature and title of certification		0		29c. License number		29d. Da	te signed (Monti	h, Day, Year)
			> Nobil	Ke	return	5	D268	39	4	120/0	6
	5		30. Name and address of person	who completed of	cause of death (Ite	om 23a) (Type Print)	1.0 Her	y DA	K42 5 1	A MAG	24(AN) 21122
No.	Sta		31. Date filed (Month, Day, Yea	5 2000	2 Registrar's Sign	latino dosel	1	(()	ישישנויע	1 1 (1)	141 114162
	Registi	rar	APR 2.	J 4000 1	A Company of the second						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** URICE 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hum offender 1 Year I if Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, **Funeral** Days Hours Year 1**™**M 2□F Yrs. Director 06.23.1948 Usual Residence of Decedent death with the Maryland 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits or Itama 23a or 28a-f ahow other traumatic avent, the Medical Examiner must be notified at 1 ☑Yes 2 ☐ No Director MD NIA BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA STREET 21223 242 N. PAYSON Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Hace - American Indian, Black, White, etc. 11. Marital Status 2 should be fited within 72 hours after or and Mental Hygiene. Is marked other than "natural", or Ital 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) COOK SELF EMPLOYED 11 TH GRADE NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WENDELL SAUNDERS THELMA EADS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Itam 27 Is any injury or other tra THELMA EADS MOTHER) 242 N. PAYSON ST., BALTO-MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State MT. 210N 04.19.06 BALTIMORE. 4 Donation 5 Other (Specify) 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE 21. Signature of Funeral Service License auxin 5151 BALTO. NATT. PIKE, BALTO. MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arm shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician my /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner for use as the burial-transit The law requires that the death certificate be executed Physician/Medicai IF FEMALE: ome of pregnancy 23b. Was decedent pregnant 23d. Date of defivery 3 Ectopic pregnancy birth 2 TFetal death in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part J. 1 23e. Did tobacco use contribute to the cause of death? Records, ۵ andio-Vascular sisease 1 Yes 2 No 3 Probably 4 Onknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? oon an teris and veins stent. 2 1 No Division of Vital Yes 2 10 No 1 Tyes Hospital or Attending Physician: filled in by the funeral director, Be 25. Was case referred to medical 26. Pface of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes ဥ 1 [] Inpatient 2 ER/Outpatient 3ET DOA 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deatl To the Funaral Diractor: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗍 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of D0026720 who completed cause of death (Item 23a) (Type, Print), 1940 West Lbert MIDY 32 Registrar's Signature State 2006

DHMH 17 Rev 1/2001

Registrar

		ı	1 - For Stata Registrar	State of Maryland / Depa	artment of Health and Natificate of Death	Mental Hygie	2.000	2835
			1. Decedent's Name (First, Middle, Las			2. Date of Death Month	_	3. Time of Death
	Physici /Medi		JOHN	SHAVERS		FPRIL.	20, 2000	6 OFM
7	Examir	er	4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death	- 1	4c. County of Death	/
			5. Social Security Number 6. Se	4050174C ENTON 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	BALTIAL	place (State or Foreign
b	Funeral Director	1		M 2□F 50 Yrs.	Months Days Hours Min.	10-9-19	35 Col	intry)
	D.		Usual Residence of Decedent 10a. State 10b. County	10g. City, Town or Lo				
	/anyla	ō	lus location in the country		O L			10d. Inside City Limits 1 Yes 2 □ No
	28a-	rect	10e. Street and Number	Gwynn	10f. Zip Code	10g.	. Citizen of What Cou	
	h with	by Funeral Director	6101 Talles Ko	ad	21207		115A	,
	me i	ner	11. Marital Status	12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Decify Yes or No-	14. Race - Ameri Black, White	
36	s afte	y Fu	1 Never Married 2 Married	1 ☐ Yes ZWNo If Yes, Give	1 ☐ Yes 2 No Specify:	7 110011, 5101,	Specify: 12	lank
21215-0036	within 72 hours after deeth with the Maryland ene. than "natural", or Iteme 23a or 28a-f ehow he Madical Examiner must be notified at	ed p	3 ☐ Widowed 4 Divorced 15. Decedent's Ed	Year or Dates:	dent's Usual Occupation	161	b. Kind of Business/Ir	dustry
215	hin 72 In "na Madii	Completed	(Specify only highest grad Elementary/Secondary (0-12)	de completed) (Give life.	kind of work done during most of work DO I OT use retired)	king	1	laddily
	filed with Hygiene. other than	Соп	2.5	5(+) Hsst.	Attorney Gen	eral	Lawye	r
Maryland	be fill hd oth	Be	17. Sather's Name (First, Middle, Last)	<	18. Mother's Nam	ө (First, Middle, Mai	den Sumame)	
ž	should be ind Mental imarkad umatic ev	ြ	1 ra. Informant's Name/Relution in (7)	Or.	ng Address (Street and Numbur or Ha	al Rouge Number, C	ity or Town State Z	n Code)
S	iges 1 and 2 should be filed within 72 hours after deeth with the Marylar it of Heaith and Mental Hygiene. If item 27 ie markad other than "natural", or Iteme 23a or 28a-f ehow or other treumatic event, the Madical Examiner must be notified at		Karen Shavers Bai	1- 15 x1 DAE1		$\mathbf{M} \cdot \mathbf{M} = \mathbf{M} \cdot \mathbf{M}$	listown 1	44
Je,	of Hea of Hea fitem r othe	=	20a. Method of Disposition	20b. Place of Dispo	osition (Name of matory or other place)		c. Location - City or T	
Baltimore,	Part and		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	lemorial 4-3	17-06 E	ial+moi	e mo
Salt	permit. Pag Depertment Important: I any injury o		21. Signature of Funeral Service Licens	See 3	Name and Address of Felix	ge tune	ral Seri	lites
	0 D ≥ € Ø		Yaughn C.	treene 8	728Liberty Rd.	Landallst	own, and	1133
			shock, or heart ailure. List only o		er the mode of dying, sum as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
,	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a consequence of):	ENCEPTACE	Alty		
	Examiner			CARDIO RES	SPIPATORY	ARRES	-	
7	D ==	ner	if any, leading to immediate	Due to (or as a consequence of):	/			
V	eath certificate be executed attending physician and for use as the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C				
8760,	be ex ician burial	ai E		Due to (or as a consequence of):				
687	ficate p phys	edicai	`	d				
Вох	h certi ending use a	N/M	23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐	75		23d. Date of deliv	ery
	ed for	slcia	in the past 12 months? 1 ☐ Yes 2 ☐ No	_	Ectopic pregnancy Other (specify)	 	Month	Day Year
P.O.	The law requires that the death certific ste has been signed by the attending p bage 2 should be detached for use as	Completed by Physician/Med	9 Unknown			00 8:44		
ds,	signed d be det	d by	DIABETUS MELL	entributing to death but not resulting in the u	OPKTHA AWD		co use contribute to t	ne cause of death? bably 4 Unknown
Division of Vital Records,	w requir been si should	ete	KEDHMERHTLES.	ENDSTAGE RENAL	2'000	24a. Was an		
æ	he lav e has age 2	dmo	Dry 1045 DA SAGG	ulin DISEASE TSCHE		autopsy performed	prior to co	opsy findings available ompletion of cause of
ţ	lan: T	0	25. Was case referred to medical	CANTON ENSE (+ X3/C	- / - / - / - / - / - / - / - / - / - /	1 Yes 2 I	No 1 □ Yes	2 40
>	Physician: this certifice ral director, p	To B	examiner? 1 ☐ Yes 2 ☑ No	Ho spital: 1 Inpatient 2 ER/Outpatien	Othor	ome 5 Residence	9 6 ☐Other (Speci	(y)
D C	ing Pl		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury 28b. Time of (Month, Day Year) Injury	Work?	28d. Describe how in	njury occurred	
isio	Attending r death. ector: After by the funer	icati	2 Accident investigation 3 Suicide 6 Could not be	One Place of Injury At home form	M 1 Yes 2 No	284 Leasting (Ctrans	A	
<u></u>	after Direct	Certification;	4 ☐ Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, ractory, office	City or Town, S	t and Number or Ruri tate)	ai Houte Number,
	ospital hours unerel ly filled	aic	29a. Certifier 1 Certifying Phy	sician: To the best of my knowledge, death	n occurred at the time, date and place,	and due to the cause	e(s) and manner as :	stated.
	I 4 II 0	edicai	(Check only 2 Medical Exam	iner: On the basis of examination and/or in- and manner stated.	vestigation, in my opinion, death occur	red at the time, date	and place, and due t	o the cause(s)
	To the I	Σ	29b. Signature and title of certifier	2	29c. License number	29d.	Date signed (Month,	Day, Year)
	2		I design	7	217307	43	10	116 kg
	X			completed cause of death (Item 23a) (Type,	Print) NEATHER 1240 - YESTER	U257 A	SPACTAL	Contra
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature		more rec	HOND (MIND)	SY 11.25
	Registr		APR 2 5 2	2006 Jeans Is of	03161			
DH	MH 17 Rev 1/20	001	TWING OF	Justine 1				

		4	For State Registrar		ryland / Depa		of He	alth an	d Mental Hyg	-) 6	128	36
· in the second		-	1. Decedent's Name (First, Middle, Last)						2. Date of Dea		Vasa	3. Time of	Death
	Physici /Medio	_	Margaret	Sz	zymanski				April 2	21, 200	6 Year	3:38	AM
	Examir		4a. Facility Name (If not institution, give s Manor Care Rossvil			4b. City, To-			Death		ty of Death		
S.	Funeral Director	1	5. Social Security Number 6. Sex 220–20–2365	7. Age	(In yrs. last birthday) 77 Yrs.	If Under 1 \ Months D		f Under 24 Hours	Hrs. 8. Date of Birt Min. (Month, Da)	6 <mark>, 19</mark> 29	9. Birth Cou Mary	place (State on ntry) land	or Foreign
	land		10a. State 10b. County		10c. City, Town or Lo	cation		_				10d. Inside C	ity Limits
	with the Maryland a or 28a-f show	ector	Maryland Baltimor	e	Edgeme:	re	- do			tos Citisas a	() Alban Carr	1 🗆 Yes	2X No
	death with	Funeral Director	8017 Dogwood Road			21	219			USA			
980	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artener of Heath and Mental Hygiene. ortant: If item 27 is marked other than "natural; or Iteme 23a or 28a-f show injury or other treumatic event, the Medical Experient must be notified at a.	by	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Was Deceden f Yes, specify 1 ☐ Yes 2X			? (Specify Yes or No- ruerto Rican, etc.)	B	ace - Ameri ack, White, ^{ify:} Whit	etc.	
21215-0036	within 72 ho ene. than "natu he Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual C kind of work of DO NOT use i	Occupation done during retired)	on ing most of	working	16b. Kind of		dustry	
	filed v Hygie other t	ပိ	8 years		Hous	ewife		0.14-46-4	No. of the Action	Own I			
Maryland	ould be fit Mental H arked ott attc ever	To Be	17. Father's Name (First, Middle, Last) James Dabrowski				N	largar	Name (First, Middle, ret Grauli)	ng			
	and 2 sho salth and n 27 is m er treum		19a. Informant's Name/Relationship (Type Joyce Elck	Daughte					r Rural Route Numbe Edgemere, I				
Baltimore,	Pages 1 nent of He int: If iter iry or oth		20a. Method of Disposition 1XX §urial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	Oak Lawn	natory or othe	er place)	P	April 24, 2006	20c. Location Dunda.			
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service License	anno	ely ?	Name 11 110 So	y Fu	ineral s Poi	Home Of I	Dundall Dundall	c,P.A.	21222	
	Physician		23a. Part1. Enter the disease of complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ations that caused the cause on each line	ne death Do not ent	er the mode o	of dying, s	such as car	rdiac or respiratory ar	nth		Approximat Interval Bet Onset and I	ween
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	cuted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of):	Ph	m	mus	^				
,092	ite be executed ysicien and ne burial-transit	cai Ex	resulting in death) Last	1 1	consequence of):	Zera	l	P	culire				
.O. Box 68	the death certifica y the attending ph iched for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	ic. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown	Fetal death 3	Ectopic pregi Other (speci					eate of deliver	•	r ear
ds, P	8 6 9	d by PI	Part II. Other significant conditions con	ributing to death but	not resulting in the u	nderlying caus	se given	in Part I.	23e. Did to	bacco use co es 2 □ No	ntribute to t		leath? Inknown
Vital Records,	e taw requir has been si ge 2 should I	nplete	Hyperl	nein		A			24a. Was a	SV	prior to co	psy findings mpletion of c	available ause of
=	The gate		Crossova	amle	taci	dent			perfor 1 ☐ Yes	2 1 No	death?	2[] No	
Vita	ician sertifi ector	Be	25. Was case referred to medical examiner?	anital:			7	6. Place of	Death Check only or	10)			
of	Physician: this certific ral director,	P.	I Tes 212AVO		2 ER/Outpatier		Other:	and the second	ng Home 5 Resid			(y)	
ion	Jing After fune	ation:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	M 28c.	. Injury at Work? 1 ☐ Yes	t s 2 □No	28d. Describe h	ow injury occi	ırred		
Division	in the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, str (Specify)	eet, factory, o	office		28f. Location (S City or Tow	treet and Nun n, State)	ber or Rura	al Route Num	ber,
	e Hospital 24 hours a e Funerel letely filled	edicai (29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of er: On the basis of e and manner state	ixamination and/or in	occurred at t vestigation, in	the time, my opin	date and p ion, death o	lace, and due to the o occurred at the time, o	ause(s) and r late and place	nanner as s , and due to	tated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	Wal-	mo		icense n	umber	64	29d. Date sign	ed (Month,	Day, Year)	-
	12		30. Name and address of person who con	npleted cause of dea	ath (Item 23a) (Type,	Print) Euta			mte 30P	BAL	Timo	re m	D 2121
	Sta Registr		31. Date filed (Month, Day, Year)	32. Fallytsivar		and .							

			1 - State Registrar	State of Ma		Depa		lealth a		ental Hyg	•	J 6	12837
	Physici	an	Decedent's Name (First, Middle, Last Susan Hunter Silv							2. Date of Deat Month 04		200g	3. Time of Death 8:30р м
	/Medic Examin	al	4a. Facility Name (If not institution, give Holy Cross Hospi	street and number)			4b. City, Town, o				4c. Cour	nty of Death	<u></u> ,
	Funeral Director		5. Social Security Number 6. Se 019-40-3054		6 (In yrs. last bii 56	rthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Birth (Month, Day, 05-25-	Year) -1949	9. Birth Cou Ma	place (State or Foreign ntry) assachusetts
	yland sow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	m or Lo	cation					1	10d. Inside City Limits
	Ba-f sh	ctor	MD Montg	omery	Takon	na F							1X Yes 2 No
	with th	Dire	10e. Street and Number 7308 Birch Ave				10f. Zip Code	20912	2	1	0g. Citizen o USA		ntry?
980	be filed within 72 hours after death with the Maryland that Hyglene. dother than "natural", or Itams 23e or 28e-f show event, Its Midfeld Examinar must be midfied at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Vas Decedent of H f Yes, specify Cuba l □ Yes 2√2 No	lispanic Orig an, Mexican, Specify:	in? (Spec Puerto F	cify Yes or No- Rican, etc.)	В	ace - Americack, White,	etc.
Maryland 21215-0036	within 72 h ene. than "natu re Modeal	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	ucation le completed) College (1-4or 5	i+)	(Give	lent's Usual Occup kind of work done DO NOT use retired	ation during most d)	of workin	g	16b. Kind of Reta	Business/In	,
/land 2	should be filed within and Mental Hygiene. marked other than umatic event, It e M.	To Be Co	17. Father's Name (First, Middle, Last) John Alexander H							(First, Middle, I		ате)	
Man	S is a		19a. Informant's Name/Relationship (T) Larry SilverMan/				g Address (Street Birch A						o Code)
Baltimore,	permit. Pages 1 and: Department of Health Important: If item 27 any injury or other tr. once.		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ 1 1 □ Donation 5 □ Other (Specify,	Removal from State			sition (Name of natory or other place ake Crema			ate 24-2006	20c. Location Belt	-	
Baltin	permit. Pages Department of I Important: If ite any injury or of once.		21. Signature of Fungral Service Licens		100382		Name and Addre Rapp Fun 933 Gist	ss of Facility eral &	cre	emation	Servi	ce	
	Physician /Medical		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	lications that caused ne cause on each lin			er the mode of dyir	ng, such as c	ardiac or	respiratory arre	est,	0,10	Approximate Interval Between Onset and Death Weeks
760, 2	Examiner Asicien and burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Oste Due to (or as	omyelit a consequence a consequence	tis of):					·		Weeks
P.O. Box 687	The law requires that the death certificate tte has been signed by the attending physioage 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 25No 9 ☐ Unknown	d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death		Ectopic pregnancy	,			1	Date of delivery	ery Day Year
Records, P	e law requires that has been signed t je 2 should be det	Completed by P	Part II. Other significant conditions conditions conditions Condit		ut nat resulting i	in the u	nderlying cause giv	en in Part I.			n 24t	3 Prob	he cause of death? Dably 4 □Unknown Dopsy findings available impletion of cause of
I Re		Com								perform	ned?	death?	
Vital	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:	ent 2 ER/O		Oth			(Check anly on ne 5 ☐ Reside		Mb /C	6.1
of	Jing After fune	H	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ry 28b.	Time of Injury	28c. Injur Wor	y at	2	8d. Describe ho			9)
Division	lel or Attendi s after death. el Director: A ed in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inj building, et	ury - At home, fa c. (Specify)	arm, str	eet, factory, office		2	8f. Location (St City or Town		nber or Rura	al Route Number,
	To the Hospitel or At within 24 hours after of to the Funerel Direct completely filled in by	Medical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Example 1	rsician: To the best iner: On the basis of and manner sta	examination ar	e, death	n occurred at the tir vestigation, in my o	ne, date and pinion, death	place, a occurre	nd due to the ca	ause(s) and ate and place	manner as s e, and due t	itated. o the cause(s)
)			29b. Signature and title of certifier	Mm I			29c. Licens D32.3			2	9d. Date sign 04–21	ned (Month, 2006	
	13		30. Name and add ss of person who consumes and sold ss of person who consumes a sure shall be seen a sure shall be said to see a sure shall be					oring :	MD 2	0902			
	Sta		31. Date filed (Month, Day, Year)	32 Registr	ar's Signature	A.	este I						
	Regist	rar	APR 2 5 20	06 Property	and States	See A	The state of the s						

		For State Registrer		State	of Mai	ryland	d / Depa <i>Cei</i>	artment of rtificate o	Health f Deat	and M h		giene Reg. No.	UÜb	403.0.40	2838
Dhysinic		1. Decedent's Nan									2. Date of Dea		. Yea	MC -	3. Time of Death
Physicia /Medic		Eloise S	Storz S	ingh							HF.KIL		., 2 0 1	06	12:20 P M
Examin	er	4a. Facility Name	Josef	n, give street and ni oh Medic	al (Cent	ter	4b. City, Town	, or Locatio	n of Death	n	4c.	County of D	eath Iti	more
Funeral Director		5. Social Security 577-54-2		6. Sex 1 ☐ M 2 ☐ F	7. Age	(In yrs. I. 71	ast birthday) Yrs.	If Under 1 Year Months Day		er 24 Hrs. s Min.	8. Date of Birt (Month, Date 02/25	h y. Year) 193	9. E DC	Birthplac Country	ce (State or Foreign
pu s		Usual Residence of	of Decedent 10b. County			10c City	r, Town or Lo	cation						100	I. Inside City Limits
faryla aho	ь	MD	Balt				keysvi							, , ,	1 ☐ Yes 2 ANo
28a-	Director	10e. Street and No	1					10f. Zip Code				10a Citi:	zen of What	Countr	17
3a or	۵	316 Cran		Road				21030					ted St		
death ma 2	Funeral	11. Marital Status		12. Was De	cedent Ev	er in U.	S. 13.	Was Decedent o	Hispanic	Origin? (Sp	ecify Yes or No-	- 1	14. Race - A		
after or ita	Fu	1 Never Mar	rried 2 Mar	ned 1 Yes	2 No)		If Yes, specify Cu 1 ☐ Yes 2 ☑ N			Hican, etc.)		Black, W		
rait,	d by	3 Widowed	4. Paivorced	Year or				10 103 22214	- Speci	.y.			Specify: Wi	nite	31
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be filed within 72 hours after death with the Maryland tall Hygiene. A other than "natural", or itama 23a or 28a-1 ahow avent, the Medical Examinat must be nutified at	ပိ	17. Father's Name	(First, Middle,	Last)					18. Mo	ther's Name	в (First, Middle.	Maiden	Sumame)		
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelth and Mental Hygiene. Important: if item 27 ia marked other than "natural", or itama 23a or 28a-1 ahow any injury or other traumatic avant, the Medical Examiner must be neithed at once.		19a. Informant's Mr. Geor					\$	ng Address (Stre				-			ode)
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/Medical Examiner		resulting in death)		Due to	(or as a	consequ	uence of):	FFICIL	= cu	TTT	2			1	DAY
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	Examin		4a. Facility Name (If not institution, Gilchrist Home	•			4b. City,	Town, or	Location o	of Death		4c.	County of Deat	
	Funeral Director		5. Social Security Number 505–36–5328	6. Sex 1√2√M 2□ F	7. Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bird (Month, Da 09-10-	h y, Yea <i>r)</i>	9. Birti Co	hplace (State or Foreign untry) Lorado
	yland		Usual Residence of Decedent 10a, State 10b, County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	r 28s-f	Director	MD N/A 10e. Street and Number			Balt	imore 10f. Zip	Code				10g. Citi	zen of What Co	x⊠Yes 2 □ No untry?
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36	n 72 hours after death with the Maryland "natural," or Itams 23e or 28s-f ehow "Nicel Examiner mast be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ Status 4 □ Divorced	Armed Fo	2 🗆 No		Was Deced If Yes, spec			gin? (Spe i, Puerto I	cify Yes or No Rican, etc.)		14. Race - Ame Black, White Specify:	
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nore,	ages 1 a int of Hei t: if itam y or othe		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation		State	Place of Disponentery, creens	sition (Nam matory or ot	ne of ther place	g)		ate	20c. Lo	cation - City or kville,	Town, State
Baltimore,	permit. Pages 1 and 2 should by Depenment of Health and Menta Important: If Item 27 is marked any injury or other traumatic evance.		4 Donation 5 Other (Sp. 21. Signatur 1 Juneral Service)		1	25	Name an	d Addres	s of Facilit	v	-			
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Division of	il or Attendi after death. Director: A d in by the fu	Certification:	3 Suicide 6 Could n 4 Homicide determine	ot be 28e. Place	of Injury - At hing, etc. (Specif	ome, farm, sti (y)	reet, factory	, office			28f. Location (City or To			ıral Route Number,
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	Sta Regista		31. Date filed (Month, Day, Year)	32. F	Registrar's Signa		K)							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician Robert Henry Snowman 23, 2006 12:10A April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death Examiner 114 Northway Rd. Reisterstown Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** XXM 2□F Months Yrs. 219-22-1155 77 May 29, 1928 Director Maryland Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10a State 10b. County rai', or itams 23a or 28a-f ehow Examiner must be notified at 1 Yes XXNo MD Baltimore Reisterstown Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 114 Northway Rd. 21136 Pages 1 and 2 should be filed within 72 hours after death vient of Heelth and Mental Hygiene. Int: If Itam 27 Ie marked other then "naturel", or Itams 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed other then "natur 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Distributor Auto Parts 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph C. Snowman Irene K. Sturgeon 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Heelth a Itam 27 I Millie Snowman /Spouse 114 Northway Rd. Reisterstown, MD. 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Importent: If Its any Injury or ot once. 1XX urial 2 Cremation 3 Removal from State 4 Donation Other (Specify) All Saints Cemetery 4/26/06 Reisterstown, MD 21. Signature Fulleral Frvice Licens 22. Name and Address of FacilitEckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 MIN 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to influentiate cause. Enter Underlying Cause (Disease or injury or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Dunknown á signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificete 2 □ No 1 ☐ Yes 2 No 1 TYes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 22 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) After thi funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No I Director: A investigation death. 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by 4 THomicide within 24 hours after To the Funeral Dire To the Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registra 2006 5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** : 24 AM 2006 /Medical 4a. Facility Hame (If not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner enesis Baltimore Health If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 219-12-767 Usual Residence of Decedent Months 1@M 2□F Director the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinating the multilied at 1 des 2 □ No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed forces?

1 ☐ Yes 2 ☐ No
If Yes, Give 2 Married 1 Never Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 72 h and Mental Hygiene. 7 Is marked other than "ne Elementary/Secondary (0-12) College (1-4or 5+) ABORER NIA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit Pages 1 and 2 should be I Department of Health and Mental I Important: If Item 27 is marked o 19b. Mailing Address (Street and Num, er or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 □Removal from State any in ury o Other (Specify) ⁴ □ Donation / uneral Service Licens 21. Signature 9 23a. Part F is the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or lear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Jause (Final disease of ondition resulting in death) Pnysician Advanced /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): esquentially list our differentially, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Due to (or a a consequence of): use as the burial-tran Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day ō in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 9 Unknown 5 Other (specify) detached 2 ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2□ No 1 Yes 2 110 To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 1 Tes 2 3 No 5 Residence 6 Other (Specify) After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: T Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 🗋 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide within 24 hours a To the Funeral L to this Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier APRIL 209006 D0053150 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

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APR 2 5 2006

31. Date filed (Month, Day, Year)

Smallwood

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Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 12:00 AM STANLEI 2006 21 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CITY TOHP'S HOPKIN'S CARS If Under 1 Year | If Under 24 Hrs. | 8 Date BALTIMORE CENTER 8. Date of Birth Month, Day, AUG. 19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Days 1 □ M 2 🖬 F 82 PA. 195-16-6718 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or Itams 23a or 28a-f show It e Magical Exampler must be notified at 1 ☐ Yes 2 X No Funeral Director MD. BALTIMORE EASTPOINT 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21224 USA 524 46TH STREET 12. Was Decedent Ever in U.S. Armed Forces?, 1 ☐ Yes 2 Û No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married lore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify. Completed by 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry l Hygiene. othar than " Elementary/Secondary (0-12) College (1-4or 5+) SECURITY INVESTIGATOR 10 0 DEFENSE : 1 and 2 should be filed wi Health and Mental Hygien tam 27 is markad othar th traumatic evant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ALICE YABLONSKI FRANK KALETA 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) itam 27 is othar tra 524 46TH STREET, BALTIMORE, MARYLAND 21224 CHARLES STANLEY/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of He
Important: If itar
any injury or oth 1 XBuriai 2 ☐ Cremation 3 ☐ Removal from State SACRED HEART OF JESUS 4/24/06 BALTIMORE, MARYLAND ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 21. Signature of Juneral Service Licensee 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 folications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part1. Enter the disease, or shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Preumonia **Physician** /Medical Due to (or as a consequence of): **Examiner** In Fluenz Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit be executed Due to (or as a consequence of) 68760 Physician/Medical requires that the death certificate IF FEMALE: Box 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. 9☐ Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. by 1 Yes 2 No 3 Probably 4 Unknown DEMEDIL Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page 2 autopsy performed certificate l 1 Yes of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No 4 ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; After or Attanding vision 1 Natural 5 Pending investigation 1 ☐ Yes 2 □ No within 24 hours after death. To tha Funeral Diractor: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D60014 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Care Center Baltimore, Johns

DHMH 17 Rev 1/200

State Registrar

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

2006

			1 - For State Registrar	State of M	arylan	-	artment of rtificate of				iene 200	5	12843
v .	Physici		1. Decedent's Name (First, Middle, Las.	")		To	RRE	S		2. Date of Deat Month	Day 23	Year	3. Time of Death
To a	/Medio Examir		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or Location of Death					of Death	
			SHOCK TA	AMUAS	4		B	ALT	MOF	ZE			
1	Funeral		5. Social Security Number 6. Se	7. Ag		last birthday) Yrs.	If Under 1 Year Months Days		Year)	9. Birthpla Count	ace (State or Foreign ry)		
	Director		373-48-6236		60) 115.				OCT 29,	, 1945	Mich	igan
	yland how		10a. State 10b. County		10c. City	y, Town or Lo						10	d. Inside City Limits
	the Marylan 28a-f ehow	ctor	Maryland Montgon	nery			Clar	ksbur	rg 				1 ☐ Yes 2 📉 No
	with th	by Funeral Director	10e. Street and Number				10f. Zip Code	0871		1	og. Citizen of USA		ry?
	eath y	erai	14920 Little Ber	12 Was Decedent	Ever in U	S 13			Origin? (Spec	rify Yes or No-		a - America	an Indian
(0	r item	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀	No		Was Decedent of If Yes, specify Cul			lican, etc.)		ck, White, e	
21215-0036	72 hours after death with the Maryland natural', or items 23a or 28a-1 ehow dical Exacilizar must be inclided at		3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1X Yes 2□ No	Specif	^{fy:} Mexi	Lcan	Specif	^{y:} Hi	spanic
5-	"natu	Completed	15. Decedent's Edi (Specify only highest grad			(Give	dent's Usual Occu kind of work done DO NOT use retire	dunna mo	ost of workin	g	16b. Kind of B	usiness/Ind	ustry
12	filed within Hygiene. other than "	dwo	Elementary/Secondary (0-12)	College (1-4or	5+)	me.	Nanny	3 0)			Chile	d Care	9
	Il Hyg other	BeC	17. Father's Name (First, Middle, Last)					18. Mot	ther's Name	(First, Middle, M	Maiden Suman	ne)	
ylar	2 should be filed within and Mental Hygiene. ie marked other than aumatic event, the Ma	To E	Luis Torres						Olivia	Martin	ez		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23e or 28e-1 ehovother traumatic event, it a Medical Experiment be redified at		19a. Informant's Name/Relationship (T				ng Address (Stree Tanglew						Code)
	1 and 3 Health tem 27 other to		Anita A. Lopez/Si	Ister	20b. P	lace of Dispo	sition (Name of				20c. Location		vn, State
ᅙ	Pages nent of I int: If its		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify				matory`or other pla ematory,		4/25/	/06	Balti	more	MD
Baltimore,	그 든 돈 글		21. Signature of Funeral Service Licens		1100		. Name and Addr						D, Inc.
m	Depa Impo any tr		Edward A Gree	gorchik			299 Fred	lericl	k Road	Balti	more, Ì	MD 212	228
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	ne cause on each li	ne.								Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. NEC Due to (or as	a consequ	TIZI uence of):	NG SO	†+ T	rssuc	= Inte	527101	4	424Hes
100	Examiner		Sequentially list conditions	b									
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	uence of):							
,	The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Exan	that initiated events resulting in death) Last	c Due to (or as	a consequ	uence of):							
8760,	ysicie he buri		(d									
9	ntifica ng ph as th	Medi	IF FEMALE:										
Вох	leath certifica attending ph	lan/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Fetal	death 3[Ectopic pregnanc	су				te of deliver	y Day Year
	that the de ned by the a detached t	Physician/Medical	1 ☐ Yes 2 ☑No 9 ☐ Unknown	4□Pregnant at 9□Unknown	t time of de	eath 5L	Other (specify)	-					
, P.O	res that I igned by be deta	by Ph	Part II. Other significant conditions co	ntributing to death b	ut not resu	ulting in the u	nderlying cause g	ven in Part	t I.	23e. Did tob	pacco use cont	ribute to the	e cause of death?
Vital Records,	v requires been sig should b									1 □ Y€	es 2 No	3 🗌 Proba	ably 4 □Unknown
ဝ၁	e law requ has been ge 2 should	Completed								24a. Was ar	n 24b.	Were autop	sy findings available inpletion of cause of
=		Соп								perform	ned?	death?	2□ No
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			O	L		(Check only on			
of		1: To	1 ✓ Yes 2 ☐ No 27. Manner of Death	28a. Date of Inju	iry	ER/Outpatier 28b. Time of	3 00	4 🗆 1		e 5 🗆 Reside)
ion	Attending Ph r death. ector: After th by the funeral	ation	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year)	Injury		ork?]Yes 2[□No				
Division	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inj building, et			eet, factory, office		28	Bf. Location (St. City or Town		er or Rural	Route Number,
	pitel o		29a. Certifier 1 X Certifying Phy	sician: To the best	of my kno	wledge deat	a coursed at the	imo dato o	and place of	ad due to the es			And
	To the Hospitel within 24 hours a VI to the Funeral Completely filled	edicai	(Check only 2 Medical Exam	iner: On the basis o and manner st	f examinal	tion and/or in	vestigation, in my	opinion, de	eath occurre	d at the time, da	ate and place,	and due to	the cause(s)
	To the To the comp	Me	29b. Signature and title of certifier	0.4.		_	29c. Licen	se number	r	29	9d. Date signe	1_	ay, Year)
	1		Malaudas	VV IX	Ma	5,1	ND PI	98	41		4/23	106	
+	1		30. Name and Iddress of person who c	ompleted cause of of the other	leath (Item	1 23a) (Type,	Print)	41 sm A					
	Sta	ite	31. Date filed (Month, Day, Year) APR 2 5 2	32. registr	ar's Signa	ture A	OCK TR	MIN					
	Registr	ar	APR 2 5 2	006 Lieu	and h	C. A	MACL!						

Registrar

APR 2 5 2006

			State of Maryland / D	a Indelible Ink. Ensu l epartment of Health a Certificate of Death	nd Mental Hyg	
Physic /Medi		Decedent's Name (First, Middle, Last) ROBERT L. THOMPS			2. Date of Dea Month	•
Examii Funeral		4a. Facility Name (If not institution, give si Good Samarita) 5. Social Security Number 6. Sex	n Hospital 7. Age (In yrs. last birth		ore	4c. County of Death A 9. Birthplace (State or Foreign Country)
Director show	J.	215-34-1832 Usual Residence of Decedent 10a. State MD BALTIMOR	10c. City, Town		2/3/193	MARYLAND 10d. Inside City Limits 1 □ Yes 2X No
th with the M 23a or 28a-f 1st be motified	al Director	10e. Street and Number 1747 GLEN RIDGE RC		10f. Zip Code 21234	1	log. Citizen of What Country? USA
Daltimore, IMaryliand ZIZI3-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked othar than "natural", or Items 23a or 28a-1 show any injury or other traumatic evant, the Midlical Examiner must be notified at 2008.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No If Yes, Give 1956-1960 Year or Dates:	13. Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican, 1 ☐ Yes 2 ☐ No Specify:	nn? (Specify Yes or No- , Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHTTE
A I A I D-UUSO Id within 72 hours af gjene. If than "natural", or If a Medical Exam	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12TH GRADE	completed) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use retired) ECURITY SYSTEMS	of working	16b. Kind of Business/Industry ADT
Maryland A d 2 should be filed th and Menta! Hygi 27 is marked othar traumatic evant,	To Be Co	17. Father's Name (First, Middle, Last) ALTON THOMPSON		18. Mother	r's Name <i>(First, Middle, I</i> RENCE DWYER	Maiden Sumame)
re, Mar 1 and 2 sho Health and tam 27 is m		19a. Informant's Name/Relationship (Type IRENE E. APSON/WIF 20a. Method of Disposition	20b. Place of	Mailing Address (Street and Number 47 GLEN RIDGE RO	AD BALTIMO	
Dallimore, permit. Pages 1 a Department of Hes important: If item any injury or othe		1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	GAIDLIN			PARKVILLE, MD FUNERAL HOME, P.A. ISON, MD 21286
Pnysician /Medical		Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	eations that caused the death. Do not a cause on each line. Metasati	ot enter the mode of dying, such as o	cardiac or respiratory arr	
g physician and as the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	0:		
ath cer attendin or use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Sc. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
he law requires that the de a has been signed by the a ge 2 should be detached t	by	Part II. Other significant conditions con	ributing to death but not resulting in	the underlying cause given in Part I.	23e. Did to	bacco use contribute to the cause of death? es 2 No 3 Probably 4 Unknown
VICAL MEC ysician: The law is certificate has bi director, page 2 sh	e Completed	25. Was case referred to medical		26 Place	24a. Was a autops perform 1 Yes	prior to completion of cause of death? 2 1 Yes 2 No
OI VII Physicia this cert al directe	To B	examiner? 1 Tes 2 No	ospital: 1 Inpatient 2 ER/Out	patient 3 DOA Other: 4 Nur	rsing Home 5 🗆 Reside	ence 6 Other (Specify)
	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Ti	ijury Work? M 1 Yes 2 N	No	ow injury occurred treet and Number or Rural Route Number,
ISION O	ficati	3 ☐ Suicide 6 ☐ Could not be			City or Town	n, State)
UNISION O ospital or Attending Ph hours after death. unaral Director: After th ly filled in by the funeral	cal Certification:	4 Homicide determined 29a. Certifier 1 Descripting Phys	building, etc. (Specify) icien: To the best of my knowledge,	death occurred at the time, date and	d place, and due to the c	ause(s) and manner as stated.
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification that the physician is on the funeral director. After this certification by the funeral director, to	Medical Certificati	4 Homicide determined 29a. Certifier 1 Descripting Phys	building, etc. (Specify) icien: To the best of my knowledge,	death occurred at the time, date and Vor investigation, in my opinion, deat	h occurred at the time, d	ause(s) and manner as stated. late and place, and due to the cause(s)
To the Hospital or Attending Pleathrands American Completely filled in by the funeral		4 Homicide determined 29a. Certifier (Check only one) 1 Certifying Phys 2 Medicel Exemin	building, etc. (Specify) icien: To the best of my knowledge, er: On the basis of examination and and manner stated.	Vor investigation, in my opinion, deat	h occurred at the time, d	late and place, and due to the cause(s)

State Registrar DHMH 17 Rev 1/2001

APR 2 5 2006

06-0259)4
Tyquan	Vinson

Please Type or Print in Black Indelible State Maryland / Department of Health and Me Hygiene

quan Vinson	1- For State	Stat		tment of Hea ficate of Dea	alth and Mel ath		200	6 1284
Physician ledical Examine	1 1 1 0 .	rst, Middle,Last)	SOM			2. Date of De Month	Day Year	3. Time of Death 2303 hrs
iodiodi Examino	4a. Facility Name (if not	t institution, give street and nu	<i>'</i>		, Town, or Location of	April 16,	4c. County of Dea	
, /	Fowley's & St.	JOHN B HOPK		пентери	timore			
Funeral Director	5. Social Security Number 217-51-6	439 1XM 2_F	7. Age (In yrs, last	t birthday) Ctudf Ui Moi Yrs.	nder 1 Year If Under hths Days Hours	Min. All C) - 93 Fore	eign A Wylasz Country)
any	Usual Residence of Dec 10a. State 10b.	. County	10c. City, To	own or Location				10d. Inside City Limits
<u> </u>	MD		Ba	Utimo				1 Yes 2 No
the hardiffee		radyAve	nue	10f. 2	2/2/7		10g. Citizen of What Co	untry?
r items 23	11. Marital Status 1 Never Married	12. Was Dec 2 Married Armed F			edent of Hispanic Origin ecify Cuban, Mexican, F		o- 14. Race - Ame White, etc.	erican Indian, Black,
s after de rall, or niner mu	3 Widowed	4 Divorced If Yes, Give Yea or Dates.			2 No specify:		Specify:	Slack
5-0036 led within 72 hours after thygiene. I other than "natural", the Medical Examiner Commisted by		ry (0-12) College (1			al Occupation (Give kii vorking life. DO NOT u		16b, Kind of Busines:	
5-0036 led within 72 hour Hygiene. other than "natt the Medical Exal	17. Father's Name (Firs	st-Middle, Last)		<u>S</u> +	Udent 18.Mother's	Name (First, Middle,		cation
ib 21215-00; should be filed with and Mental Hygiene 7 is marked other that revent, the Med To Be Com	eric t	Purnell			Al	CIAV	inson	
and 2 should and 2 should dealth and Me tream 27 is ma traumatic ev	Alicia	Relationship (Type, Print)	104ler)	19b. Mailing Addre		Ave, E	mber, City or Town, Sta	te, Zip Code)
F = F = F	20a. Method of Disposit 1 Burial 2 0	tion Cremation 3 Removal fr	1	ace of Disposition (Nematory or other pla	· /	Date	20c. Location - City of	
Baltimore, permit. Pages la Department of He Important: If ite injury or other ti	4 Donation 5 21 Signature of Funera	Other Specify: al Service Licensee	/4+	·· / I ON (entetery ity	4/24/0	weral Si	one, MI)
	23a. Part I. Enter the di	sease, or complications that c	01363	Vang	55 LOK e of dying, such as car	K. P.d.	Bulto MI	2 12 12 Approximate Interval
Physician /Medical		ne cause on each line.					ronary artery	Between Onset and
xaminer	or condition resulting in	Due to (or as a	a consequence of):					
iner	Sequentially list condition if any, leading to immediate cause. Enter Underlying	diate Due to (or as a	a consequence of):					
ted J Insit Examiner		milialeu -	a consequence of):					
'60, ate be executed bhysician and te burial - trans	X UNPENDED		item#23a,2	7,4a,perME,	g856,6/12/06	TT		
ox 68760, and certificate be ex- attending physician for use as the burial.	IF FEMALE: 23b. Was decedent preg past 12 months?	gnant in the 1 Live b		2 Fetal dea	th 3 Ectopic p	regnancy	23d. Date of delive Month	Day Year
Box 687 e death certific the attending p ed for use as th	1 Yes 2 No 9		nant at time of death own	Other (S	pecify)			
i, P.O. Bc ires that the de signed by the z	Part II. Other significan	nt conditions contributing to	o death but not resu	ulting in the underly	ing cause given in Part		tobacco use contribute t	o the cause of death?
Records, The law require: ficate has been sig	<u></u>					24a. Was	s an 24b. Were a	autopsy findings available completion of cause of
Division of Vital Records, tal or Attending Physician: The law require a star death. a) Director: After this certificate has been side in by the funeral director, page 2 should burification: To Re Compulation							ormed? death?	· —
ital Recician: The scerificate rector, page	25. Was case referred to examiner?	Hannital:	1	D(0 + 1; + 0	26 Place of Death (C		la (
n of Vi ing Physi After this funeral dir		No ' '	Inpatient 2 V EF of Injury n, Day, Year)	8b. Time of Injury	DOA Other 4 1	Nursing Home 5 28d. Describe	Residence 6 Oth	er:
Sion Attendi	1 X Natural 5	Pending Investigation		a form street feet	1 Yes 2 N		(Stead and Number -	Design Number City
Division os spiral or Attending nours after death. neral Director: After filled in by the func	3 Suicide 6 4 Homicide	Could not be determined (Specify)		e, fami, street, facti	ory, office building, etc.	or Town,		tural Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit Madrical Certification: To Re Completed by Physician/Medi		tifying Physician: To the bes	of examination and					
To with Com	29b. Signature and title	and manner s	itated	- :	29c. License number		29d. Date signed (M	onth, Day, Year)
	Throde	ell King	Com	20)	O.C.M.E.		April 17, 2006	
100	Theodore King	of person who completed court MD. Assistant Meur			reet, Baltimore, N	1D 21201		
Stat Registra		(ay, Year) 32. Be	egistrar's Signature	Locate				

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APR 2 5 2006

ORIGINAL

		-	For State Registrar	State of M	aryland / Do	epartment Certificate				ene ()	06	12847
			1. Decedent's Name (First, Middle, L	ast)					2. Date of Death Month	Day	Year	3. Time of Death
	hysici: /Medic		Grace	homo homo		VanLan	lingh	am	A 6	0 2	006	0420 AM
4	xamin		4a. Facility Name (If not institution, g	-: 1			own, or Location				y of Death	
				ospital			on dall			13	altrn	
	neral			Sex 7. Ag 1 ☐ M 2 🕱 F	ge (In yrs. last birth	Months	Year If Und Days Hour	s Min.	(Month, Day,		9. Birth	olace (State or Foreign ntry)
Dire	ector		212-26-5733 Usual Residence of Decedent		104	3.			July 22,	1901	Kar	sas
land	ě n		10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
Mary		Ď.	Maryland Baltimo		Randa11	stown						1 ☐ Yes X ☐ No
the	r 289	rec	10e. Street and Number	re		10f. Zip 0	Code		10	g. Citizen of	What Cou	ntry?
72 hours after death with the Maryland	rthen "natural", or tems 23a of 28e-1 ehow the Medical Examinermust be notified at	Funeral Directo	3801 Schnaper D	rive # 402		21	133		Unii	ted St	ates	of America
deat	E B	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Decede		Origin? (Spe		14. Ra		can Indian,
after	9 8	F	1 Never Married 2 Married			1 🗆 Yes 2			1110411, 010.)			asian
Z I Z I 3-UU30 od within 72 hours aff giene.		d by	3 Widowed 4 □ Divorced	Year or Dates:		-						
72.1	3	Completed	15. Decedent's (Specify only highest g		1 (Decedent's Usual Give kind of work ife. DO NOT use	done durina m	nost of worki	ng 1	6b. Kind of E	Business/Ir	dustry
within ene		E C	Elementary/Secondary (0-12)	College (1-4or	5.1)			d Home	e Maker	Educa	tion	
4 9 01	5 E		17. Father's Name (First, Middle, La		1		18. Mo	other's Name	(First, Middle, M	aiden Surna	me)	
ental	64 of	o Be	John Frederick				Ann	a Mart	tha Pope			
Maryiand of 2 should be file lith and Mental Hy	mati mati	ဥ	19a. Informant's Name/Relationship		19b. I	Mailing Address (al Route Number,	City or Town	, State, Zij	o Code)
Ma 142 s	27 is treu		Suzan Miller		1							ryland 2115
D 8 8	item 27 is marked othe other treumatic event,		20a. Method of Disposition		20b. Place of I	Disposition (Name crematory or oth	9 of	7.00		0c. Location		
Page:	بر بر م		1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			-		04/2	24/06	Svkeev	i11a	Maryland
Dallinore, permit. Pages 1 a Depertment of Hea	fnju	1	21. Signature of Funeral Service Lic		Luite VI							Directors,
D Ed	eny f		marke t	ollner M	00333							and 21133
			23a. Par1. Enter the disease, or co	mplications that cause	d the death. Do no							Approximate Interval Between
Dhye	sician		shock, or heart failure. List on Immediate Cause (Final			И						Onset and Death
	dical		disease or condition resulting in death)	Due to (or as	a consequence of	hy						Years
Exan	niner			b. Arter			nvascu	Mar	diseas	6		Years
	,	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):						
outed	physicien and the burial-transit	Examine	that initiated events	c. Valvul Due to (or as	ar Hea	rt dis	eose	mitro	al regu	rgital	Ton	Years
) š	en an urial-t		resulting in death) Last	Due to (or as	a consequence of):				J		
ate be	he bu	Ical		d								
Hecords, P.O. Box 68/60, The law requires that the death certificate be executed	ing pl	Physician/Med	IF FEMALE:							10		
Box Bath cert	attending p	an/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □Ectopic pre					ate of deliv	ery Day Year
, e	the a	Sic	1 ☐ Yes 2 Ø No 9 ☐ Unknown	4□Pregnant a 9□ U <i>n</i> known	t time of death	5 ☐ Other (spe	cify)					,
E ta	detached	5	Part II. Other significant conditions	contribution to double	out not reculting in	ho undoshina oo	uso enven in Da	o# 1	23e Did tob	acco use cor	stribute to I	he cause of death?
ies t	200	۵		-		,	use giveii iii ra		1	22/No		bably 4 □Unknown
	speen s	ed	Chronic ren	in insurv	Terency				Laka			
OT VICAL MECOLOS, Physicien: The law requires t	2 0	Completed	Diabetes me	ellitus					24a. Was an autopsy		prior to co	opsy findings available empletion of cause of
F 1		ပိ							perform 1 ☐ Yes 2	Ø No	death?	2 No
cien :	certificete irector, pa	Be	25. Was case referred to medical examiner?	Hospital:			Other		(Check only one			
OI VILA Physicien:	this ald	၉	1 Yes 2 No	I Jinpati		patient 3 DOA			me 5 Resider			fy)
	After	Certification:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inj (Month, Da		ury M	lc. Injury at Work? 1 ☐ Yes 2	1	28d. Describe how	w injury occu	rred	
UIVISION I or Attending after death.	the the	icat	2 Accident investigat 3 Suicide 6 Could not	be 290 Bloom of In	jury - At home, farr				28f. Location (Str.	eet and Num	her or Rur	al Route Number
after A	Direc in by	ertit	4 Homicide determine	building, e	tc. (Specify)	ii, stieet, lactory,	Olilos		City or Town,		001 01 1101	ar riodio riomodi,
To the Hospital	To the Funeral Dire completely filled in b	O T	29a. Certifier 1/2 Certifying	Physician: To the best	of my knowledge	death occurred a	t the time date	and place	and due to the ca	use(s) and m	anner as	stated.
Hos 24 h	etely	ledical		aminer: On the basis of and manner si	of examination and							
To the within 2	ompl	₩ We	29b. Signature and title of certifier			29c.	License numb	er	29	d. Date sign	ed (Month,	Day, Year)
F 51			D Roggle	_	MO	E	S S S	544	1	Poril	20	2006
in 7			30. Name and address of person wh	o completed cause of	death (Item 23a) (1	vpe, Print)				1		
10.	-			00 Old 6	-ourt R	sad Su	uite 1	08	Randal	GTOW	n	2006 MD 21133
	Sta	ate	31. Date filed (Month, Day, Year)	32 Regist	rar's Signature	A 40						
F	Regist	rar	APR 2.5	2006	rar's Signature	1982						

	_	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Por State Registrar
Physiciar /Medica		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month: Day Year 455 AM
Examine Funeral	r	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Maryland 21215-0036 and 2 should be filed within 72 hours after death with the Maryland all hand Mentel Hygiene. 27 ie marked other then "neturel", or liems 23e or 28e-f show are treumetic event, the Medical Exertine must be notified at the medical process.	to be completed by runeral Director	State 10b. County 10c. City, Town or Location 10d. Inside City Limits 10d. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 10d. State 10b. County 10d. Inside City Limits 10d. Street and Number 10d. Street and Number 10d. Zip Code 10g. Citizen of What Country? 10d. Inside City Limits 10d. Zip Code 10d. Citizen of What Country? 10d. Zip Code 10d. Citizen of What Country? 10d. Zip Code 10d. Citizen of What Country? 10d. Zip Code 10d. Citizen of What Country? 10d. Zip Code 10d. Citizen of What Country? 10d. Zip Code 10d. Citizen of What Country? 10d. Zip Code 21d. Zip C
Baltimore, M permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr		20a. Method of Disposition 1 Burial 2 Cemation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY 4-25-2006 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MD 21217
De principal	iicai Examiner	23a. Par Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caue. (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):
P.O. Box 687 nat the death certificate d by the attending phys letached for use as the	Pnysician/medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
Records, e law requires thas been signed to 2 should be d	Completed by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vinknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
Of Vital Physician: this certifical director, and director	lo be	25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Place of Death 28. Describe how injury occurred 28. De
	ical Certification:	Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28g. Location (Street and Number or Rural Route Number, City or Town, State) 28g. Location (Street and Number or Rural Route Number, City or Town, State) 28g. Location (Street and Number or Rural Route Number, City or Town, State)
To the within 2 To the Complet	Medical	29b. Signature and title of certifier 29c. License number DDD59423 April 24 2006
State Registra	_	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Notification & 60 (Jankarian Bi) PDB# 303 Ba (brown mp 28239 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

			State of Maryland / State of Maryland / Registrer		rtment of Hotificate of L			iene	36	12849
	Physicia	20	Decedent's Name (First, Middle, Last)	-			2. Date of Deat Month	Day	Year	3. Time of Death
	/Medic		Norman John Wis	e			Apri1	19	2006	8:40 P.M
	Examin	er	4a. Fecility Name (If not institution, give street and number) 221 Atlanta Road		4b. City, Town, or Pass	Location of Death adena		4c. County		rundel
	Funeral .	-	5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth			lace (State or Foreign
П	Director		214 03 3876 10xm 2 F 88	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Dey, June 30	, 1917	Mar	yland
	P 2		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	aum or Lo	ation					0d. Inside City Limits
	Aaryia Febor	٥		sader						1 ☐ Yes 2 ☑ No
	19 1 28e-	rect	10e. Street and Number		10f. Zip Code		10	og. Citizen of V	What Cour	ntry?
	th with	a D	221 Atlanta Road		211	.22		U.S.		
	ems.	Iner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. \	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Sp	ecify Yes or No-		e - Americ	
30	be filed within 72 hours after death with the Maryland tal Hyglene d other then "neturel", or items 23e or 28e-f ehow event, i're Medical Exaction must be rediffed at	by Funeral Directo	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give WW II.	1	☐ Yes 2☑ No	Specify:			. Whi	
9500-91212	turel		15. Decedent's Education 16	Sa. Deced	ent's Usual Occupa	tion		16b. Kind of Bu	usiness/Inc	dustry
212	filed within 72 Hygiene. Ither then "nei int, it e Medic	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. L	kind of work done di OO NOT use retired)	uring most of work	ring			,
	filed withi Hygiene. other ther	Con	5+ years	Teac	· · · · · · · · · · · · · · · · · · ·			Mary1a		ate
מב	ntal H ed oth	Be	17. Father's Name (First, Middle, Last) John Oscar Wise				e (First, Middle, A Barbara		- /	
Maryland	should and Men is marke	၉		9b. Mailin	g Address (Street a					Code
	s 1 and 2 should the should be shoul		* ** /		tlanta Ro		adena, M			
Ze,	iges 1 a nt of Hea : if item or othe		20a. Method of Disposition 20b. Place	of Dispo	sition (Name of natory or other place	e)	Date 2	20c. Location -		
Ĕ	Part and ury		1 GBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	tate	Veteran (Cem: 4/24	/2006			, Maryland
Baltimore,	permit. Pag Depertment Important: eny injury o		21. Signal 11 of Fureral Service Licensee	22	Name and Address	s of Facility G	once Fund			•
_	402.0	-	23a. Part1. Enter the disease, or complications that caused the death. D						Mary.	Land 21225 Approximate
	D		shock, or heart failure. List only one cause on each line.				or respiratory arre	ist,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	DI YA	ory tall					1 month
	Examiner		1 di anothic	Auli	nunavu 6	Elbrasis				42925
	D H	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ce of):						
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C	o of/:						
3/60,	ate be ex nysician he burial	calE	1	30 01).						
80	death certificate be executed a attending physician and id for use as the burial-transit		0.							
X Q Q	leath certific attending p	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal dea	ath 3□	Ectopic pregnancy				te of delive	•
5	at the dea by tha at tached fo	sici	in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown		Other (specify)			Мо	nth	Day Year
7.	law requiras that the as been signed by th 2 should be detache		Part II. Other significant conditions contributing to death but not resulting	a in the ur	dertving cause give	n in Part I.	23e. Did tob	acco use cont	ribute to th	e cause of death?
ds,	uiras tha signed l	d by			, ,		1 □ Ye	s 2 No	3 ☐ Prob	ably 4 □Unknown
ecord	aw require as been sig 2 should b	Completed					24a. Was ar		Were auto	psy findings available
r	The age	E O					autopsy perform	19d2 0	death?	npletion of cause of 2□ No
VITA	eician: certifica rector, p	Be	25. Was case referred to medical examiner?				h (Check only one			
6	shys this at di	2		Outpatien		4 🗆 Nursing no	ome 5 Reside			′)
	After fune	tlon	1 Matural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury	28c. Injury Work M 1 □ Y	al ? ′es 2 □ No	28d. Describe ho	w injury occurr	red	
DIVISION	Attender death	Ifica	3 Suicide 6 Could not be 28e. Place of Injury - At home,	farm, stre	eet, factory, office		28f. Location (Str	eet and Numb	er or Rura	I Route Number,
בֿ	rs eftar d ei Direct ed in by i	Certification:	4 ☐ Homicide building, etc. (Specify)				City or Town	, State)		
	To the Hospital or within 24 hours eftu To the Funeral Discompletely filled in		29a. Certifier (Check only Medical Examiner: On the basis of examination					use(s) and ma	inner as st	ated. the cause(s)
	To the within 2 To the complet	Medical	one) and manner stated. 29b. Signature and litter of certifier		29c. License	number	29	d. Date signed		
)	⊬ ≱ ∓ 8		Hunt Jank mo		000	22483		april		
	102		29b. Signature and little of certifier 30. Name and address of person who pleted cause of death (Item 23: STUART JACOBS MD 3 US NUS 31. Date filed (Month, Day, Year) APR 2 5 2006	a) (Type,	Print)	Α				
	10		STUART JACOBS MD 305 NOS	ortel	Q1, CH	en Burn	u, mo	2106		
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Aces	Es 1					
	negisti	31	APR 2 5 2006 Medica A	A STATE OF THE PARTY OF THE PAR						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0.0.0

			1 - For State Registrar	State of Maryland		triment of F tificate of			iene () () ()	12850
	Physici	20	1. Decedent's Name (First, Middle, La	·		-		2. Date of Deat Month		3. Time of Death
	/Medi			ICHAEL ROBERT	I WHI	TMORE		APRIL	23, 200	
	Examir	ier	4a. Facility Name (If not institution, giv	•			or Location of Death		4c. County of De	
			514 LAKES COUP 5. Social Security Number 6. S		st hinthday)	WEST	MINSTER If Under 24 Hrs.	8. Date of Birth	CARRO	
	Funeral Director			2 M 2 □ F 4 3	Yrs.	Months Days	Hours Min.	12/26/	Year) 1962 M	Birthplace (State or Foreign Country) ARYLAND
	laryland •how		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	n the Marylar r 28a-f ehow incitited at	cto	MD CARRO	LL WE	ESTMI	NSTER				1 X Yes 2 ☐ No
	or 28	Director	10e. Street and Number			10f. Zip Code		11	0g. Citizen of What	Country?
	death with the Maryland me 23a or 28a-f ehow r maat be notified at	rai	514 LAKES COU			2115			USA	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Iteme eny Injury or other treumatic event, the Medical Examination once.	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No ff Yes, Give Year or Dates:		Vas Decedent of H Yes, specify Cubi ☐ Yes 2 No	lispanic Origin? (Spec an, Mexican, Puerto R Specity:	cify Yes or No- lican, etc.)	14. Race - Ar Black, W	
5-0	"natu	etec	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(Give	ent's Usual Occup	during most of workin	g	16b. Kind of Busines	ss/Industry
121	within ene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		70 NOT use retired ${ m TRAINER}$	•		UARTER	HORSES
d 2	Hygin Hygin Sther	0	17. Father's Name (First, Middle, Last)			11(111111111111111111111111111111111111	18. Mother's Name		1 = 1	IONDES
lan	fental fental rked c	To B	ROBEI	RT STERLING W	HITM	ORE	ESTHER	MAE S	MITH	
Maryland	and N		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street	and Number or Rural	Route Number,	City or Town, State	, Zip Code)
	ss 1 and 2 of Health Item 27		AMY LYNN WHITMO		514 1	LAKES C	OURT, WES	STMINS	TER, MD.	21158
Baltimore,	ges 1 t of H if Ite		20a. Method of Disposition 1 ↑ © Burial 2 ☐ Cremation 3 ☐	Removal from State	ce of Dispos netery, crem	sition (Name of natory or other place	Da	ite 2	20c. Location - City	
ţ	t. Partmen		1√ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify						ANEYTOW	•
Bal	permit. Page Department of Important: if eny Injury of once.		21. Signature of Sinery Service Licer	S00	22.	Name and Addre	ss of Facility FLE	TCHER	FUNERAL	HOME
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	ofications that caused the death.	Z 5	or the mode of dvir	ALN ST.,	WESTMI	NSTER,	MD. 21157 Approximate
*	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	() []	cer					Interval Between Onset and Death
14	e is	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a sunsequer	nos of).					
~	and and II-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequer	nce of):					
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89	ifficate g phy as the	edicai		u,						
P.O. Box	The law requires that the death certificate be execu sie has been signed by the attending physician and page 2 should be detached for use as the burial-trai	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnanc 1 Live birth 2 Fetal de 4 Pregnant at time of deat 9 Unknown	eath 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
	gned gedet	by P	Part fl. Other significant conditions of	ontributing to death but not resulti	ing in the un	derlying cause give	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?
Records,	w requires to been signer should be a	ted						1 🗆 Ye	s 200 No 3□1	Probably 4 □Unknown
ec	lawr nasbe e2sh	Completed						24a. Was an autopsy	prior to	autopsy findings available completion of cause of
	siclen: The law certificete has t irector, page 2 s							perform	ed? death?	es 2 No
Vital	Physiclen: this certifice ral director, I	Be	25. Was case referred to medicaf examiner?	Hospital:		3U DOA Oth	26. Place of Death (·	
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ion	Attending Indeath.	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	28c. Injun World	k? Yes 2 □ No	a. 20001120 1101	windary occurred	
Division	r Attendi er death. rector: A by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	et, factory, office	28	f. Location (Stre City or Town,	et and Number or I	Rural Route Number,
Ö	itel or irs aft rel DI led in	Cer								
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificete his completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 1 Certifying Ph. 2 Medical Exam	rsician: To the best of my knowle iner: On the basis of examination and manner stated.	edge, death n and/or invi	occurred at the timestigation, in my of	ne, date and place, an pinion, death occurred	d due to the car I at the time, da	use(s) and manner te and place, and di	as stated. ue to the cause(s)
•	To with	≥	29b. Signature and title of certifier	DIRECTOR, MEDICAL DAX	טוטויא	29c. License	23675	29	d. Date signed (Mor	7MG
	4	1	30. Name and address of person who of	ompleted cause of death (tem 2	a) (Type, P	(int) -1 0	Q. 1	אשוו ביי	a MNO	21221
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	Δ	todon for		Mom	1 1110	~1-01
	Registr		APR 2 5 2	2006 Janes A	E Ale	and a				

			State of Maryland / Department of Health and M 1- State Registrar Certificate of Death		a UUU	12851
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Deat	eg. No. th Day Year	3. Time of Death
	/Medic	ai	4a. Facility Name, (If not institution, give street and number) 4b. City, Town, or Location of Death	agril	19 Jeeg 4c. County of Deat	09:30pM
	Examin	er	The Johns Hopkins Hospital Battimore Co	Fee	N/	
	Funeral		5. Social Security Number & Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8 Date of Birth (Month, Day,		hplace (State or Foreign untry)
*	Director		220-38-8316 12 Min. July 1 Gardent 12 Min. Ju	04/23		RYLAND
	within 72 hours affer death with the Maryland ane. then "neturel", or Items 23a or 28e-1 show the Marical Examiner must be notified at	1	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Be-f s	ecto	MD N/A BALTIMORE CITY			Y☐Yes 2☐No
	with ti	Funeral Director	10e. Street and Number 1728 N. COLLINGTON AVENUE 21213	1	0g. Citizen of What Co USA	untry?
	death ms 23	nera	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14. Race - Ame	
36	s after or Ite	by Fu	1 ☐ Never Married 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 No 1 ☐ Yes 2 Married 1 ☐ Yes Give 1 ☐ Yes 2 Married 1 ☐ Yes 2 M	Hican, etc.)	Specify: BI	
21215-0036	hours		3 Wildowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business/	
215	thin 72 B.	Completed	(Specify only highest grade completed) (Give kind of work done during most of work file. DO NDT use retired)	ing		,
21	filed wit Hygiene other the		7TH DISABLED		DISABLE	D
Maryland	9 E D S	To Be	17. Father's Name (First, Middle, Last) LEROY WHITE ALICE		•	
lary	2 should the and Ment Is marked eumetice	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura	al Route Number	, City or Town, State, 2	
	1 and 2 Health tem 27		LUCY WHITE / WIFE 1728 N. COLLINGTON 20a. Method of Disposition (Name o			·
mor	Pages nent of hant of hant: If ite		20a. Method of Disposition 1 ABurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20c. Location - City or LANSDOWN	
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature and Address of Facility HO 4600 LIBERTY HEI			
٠	-		23a. (Agr.) . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac c			Approximate
	Pnysician ₁		Shock or heart fature. List only one cause on each line. Immediate Cause (Final disea e condition Circle)	an		Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	17		2 40%
	<u> </u>	e.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	KE		3 days
	outed d ansit	Examiner	Superitially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	}		4 days
oʻ	cate be executed bhysician and the burial-transit	i Exa	resulting in death) Last Due to (or as a consequence of):			
8760,	physic the b	dicai	d			
Вох 6	eath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of deli	verv
	death a atte ed for	Physiclan/Me	in the past 12 months? 1 Yes 2 No 1 Yes 2 No 1 Other (specify)		Month	Day Year
P.O.	that the de led by the a detached i	Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23a Did toh	pacco use contribute to	the eques of death?
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eco	e law requ has been je 2 shoul	Completed		24a. Was ar		topsy findings available ompletion of cause of
<u>~</u>	sician: The lar certificate has rector, page 2	Con		perform	ned? death? XX No 1 ☐ Yes	2 No
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of	g Phys er this eral di	-	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 2		ence 6 Other (Spec ow injury occurred	ify)
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Division of	al or Att after de I Direct d in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Sti City or Town	reet and Number or Ru n, State)	ral Route Number,
	To the Hospital or Attending Physician: whith 24 hours after deals. To the Funerel Director: After this certifical completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the ca ed at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To th within To the	Me	29b. Signature and title of certifier 29c. License number	29	9d. Date signed (Month	Day, Year)
			James Pholeback ML Rt S-000	1	troil 19	2000
	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tamer Abdelhak 500 N, Wolfe Street B	altimo	ve MD	21287
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 5 2006 32. Registrar's Signature			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death April **Physician** 23, Milton J. walker 4:40 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 3901 Hannon Ct., Unit 2B Baltimore Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 1, 192 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F 218-09-4862 Director Maryland Usual Residence of Decedent death with the Maryland 10a State 10b County 10c, City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 3901 Hannon Ct., Unit 2B 21236 U.S.A. "natural", or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. nent of Health and Mental Hygiene. ant: if item 27 is marked other than "natural", or iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify onfy highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Estimator Martin Marietta 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Kowalski Mary Woitowicz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Walker 3901 Hannon Ct., Unit 2B, Baltimore. MD 21236 (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of h Important: If ite any injury or of once. 1 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State St. Stanislaus Cem. 4/26/2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine and I-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Cther (specify) P.O. F 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, sign 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♣ No 24a. Was an autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death | Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funeral Dire 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certi-Log cause of death (Item 23a) (Type, Print)
7566 North Point Pv. Paltines 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

				1 - For State Registrar	State o	f Marylaı		artment o <i>rtificate</i>			Mental Hy	giene Reg. No	UUD	12	2853
			11	Decedent's Name (First, Midd	le, Last)						2. Date of De	eath Da	y Yea		Time of Death
-		Physici /Medic		Frances Cather	ine Willan	cd					April		2006	1	41 A. M
		Examin		4a. Facility Name (If not institution	n, give street and nu	m <i>ber)</i>		4b. City, To	wn, or Locat	tion of Death	ר		County of De		
				Gilchrist Cent	er 6. Sex	7 A = 2 //n um	lant hirthday	If Under 1 \	Towso	II nder 24 Hrs.	R Date of Bi	Th.	Baltimo	ore Co	ounty State of Foreign
		Funeral		5. Social Security Number	6. Sex 1 □ M 2024F	7. Age (III yrs	. last birthday) Yrs.		Days Hou		8. Date of Bi (Month, Di April 2	ay, Year) 7 1 (10 76	country)	State or Foreign
		Director		214-18-2056 Usual Residence of Decedent		- 00					April 2	2/,12	719 AS	olitaile	A PMD •
		yland		10a. State 10b. County	/	10c. C	ity, Town or Le	ocation							side City Limits
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		or 28	Director	10e. Street and Number				10f. Zip Co	ode			10g. Cit	izen of What	Country?	
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8	2	and Health Im 27 her tr		Mr. Robert E.	Covahey (B		Place of Disp	7 Crems			Phoenix		aryland		131 State
10	0	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from	State	cemetery, cre	matory or othe	ar place)	1	Lacorda,				
yllam	altimore, Maryland 21215-0036	t. Pa ttmen rtant: njury		4 Donation 5 Other (Ev	ans Fu	neral (op _	Fo	orest I	1111,	Maryland
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		/Medical		resulting in death)	d	(or as a conse								1	
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	387	icate phys s the	edicai		d										
	Box 6	The law requires that the death certific ete has been signed by the attending p page 2 should be detached for use as	Z/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of preg	nancy						23d. Date of	delivery	
		death e atte d for	Cia	in the past 12 months? 1 □ Yes 2 W No	4∐Preg	birth 2 □ Fe nant at time of		□Ectopic preg □ Other <i>(spec</i>					Month	Day	Year
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9	ū	ding P. h. After t funera	OU	27. Manner of □eath 1/□Natural 5 □ Pend	ing .	of Injury oth, Day Year)	28b. Time Injury		Work?	0 T N	28d. Describe	how inju	iry occurred		
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		10		30. Name and address of person	n who completed car	ise of death (It	em 23a) (Tvos	a. Print)	, , ,	,	,				_
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	1	For State Registrar	State of Maryland /		artment of Hetificate of L			iene	6	2854
		Decedent's Name (First, Middle, Last,					2. Date of Deat	h	Year .	3. Time of Death
Physici		Rubert F	E. Webb				AOV 1	21	2004	11:55AM
/Medic Examin		la. Fecility Name (If not institution, give			4b. City, Town, or	Location of Death	19.	4c. County	of Death	
Examin	eı	Franklin Woods			Baltimo	ore		Bal	timor	e
Funeral		5. Social Security Number 6. Set		oirthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,			lace (State or Foreign try)
Director		141-14-0845	M 2□F 89	Yrs.	Months Days	Hours Min.	Mar. 30			 Virginia
		Usual Residence of Decedent								0d. Inside City Limits
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th th	lire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of	What Coun	itry'?
th wi	Funeral Director	515 Ekhart Drive			21085			USA		1-2
swe swe	inel	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. 1	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecity Yes or No- Rican, etc.)		ce - Americ ck, White,	
:1215-0036 within 72 hours after deeth with the Maryland ene. than "natural", or Hems 23e or 28e-f ehow than "natural" ar instructional be notified at	Y.	1 Never Married 2 Married	1 X Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2 💢 No	Specify:		Specif	y: wh	nite
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21215-0036 sd within 72 hours aft giene. er than "natural; or it in M. dical Exami	Completed	15. Decedent's Edu (Specify only highest grad		(Give	kind of work done of DO NOT use retired	turina most of work	ing	100.11110010		
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ntal l	Be	Harry Vaye Wel	nh.			Mable	Anice	Lethe	rman	
d Me	오	19a. Informant's Name/Relationship (T		9b. Maili	ng Address (Street a	and Number or Rui	rai Route Number	, City or Town	, State, Zip	Code)
In Fe, Maryland 21215-0036 Is 1 and 2 should be filed within 72 hours after deeth with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f ehow other traumatic event. Ins Medical Examiner risust be notified at		Kenneth E. Webb -		907	Silver S	mice Tar	ne. Abin	don. M	arvla	and 21009
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S effe	Certification;	1 I I I I I I I I I I I I I I I I I I I	building, old. (apasily)							
Division of Vita Volta Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying Ph	ysician: To the best of my knowle	and/or i	avactication in my o	oninion death occu	irred at the time	date and place	and due i	to the cause(s)
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To ti withii To ti	Ž	29b. Signature and title of certifier	Ω		29c. Licens	se number		29d. Date sign	ed (Month	, Day, Year)
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EX		30. Name and address of person who	completed cause of death (Item 23	За) (Туре	, Print)	A		111	- /	A
う		Tom Edminds	on, MD 9105 FI	ank	lin Sylvare	e Dr. Ste	. 312, Ba	17 mor	PM	02/237
	tate	31. Date filed (Month, Day, Year)	and manner stated. MO completed cause of death (Item 2: 2. Aegistrar's Signatur	9	and s	/	,		/	
Regis	trar	APR 2 5 201	16 Morens A.							

State of Maryland / Department of Health and Mental Hygiene [For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Physician <u>11</u>:05 A[™] 4-20-2006 Herman Wefelmeyer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 868 Stevenson Road Severn Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days 1XXM 2□F Yrs. 83 8-6-1922 Director 218-18-1137 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County worde I r then "natural", or items 23s or 28e-f ehoven the Modical Examiner must be notified at 1 ☐ Yes 21 No MD Anne Arundel Severn Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 868 Stevenson Road 21144 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. hours after 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: white Specify: ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation within 72 (Give kind of work done during most of working life. DO NOT use retired) other then Elementary/Secondary (0-12) College (1-4or 5+) craftsman Nevamar Corporation 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 end 2 should be filk Depertment of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event Be Edward Wefelmeyer Marie Deichgraber 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Mary Wefelmeyer / wife 868 Stevenson Road; Severn, MD 21144 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Deichgraber Cemetery 4-25-2006 Severn, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home, PA once Mo/35 1 Second Ave SW; Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ancer Physician SYUN /Medical Due to (or as a densequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.0. been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, \$ 1 2 Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificete has t director, page 2 s 1 ☐ Yes 2 ☐ No 1□ Yes of Vital Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 Mo Medical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Division 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide ō the Hospitel 🕊 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D53462 am 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OAKWOOD Rd. Glen Purvie, MA Jude MD 7845 Monese 31. Date filed (Month, Way, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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2006

State of Maryland / Department of Health and Mental Hygiene 12856 Amend Item #20b Per FH G854 an 1654 to 60 the eath 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Month Year **Physician** BERNICE CALVERTA FRANCIS WATSON 11:25 PM April e 12 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore at NA Jinau Balti more Hospital If Under 1 Year | If Under 24 Hrs. 8. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 SF Yrs. Director 212.20.5903 02.03.1922 Usual Residence of Deceden 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits item 27 is marked other then "neturel", or items 23s or 28s-f show other treumstic event, the Mudical Examinar must be notified at 1 Yes 2 No Directo MD BALTIMORE CATONSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 801 LANE # 445 WINKERS USA 21228 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ Specify: BLACK 3 Widowed 4 X Divorced and Mental Hygiene. Is marked other then "neturel", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 4 YR8 Elementary/Secondary (0-12) EDUCATOR BALTIMORE CHY 12 TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be f and Mental I LOUIS FRANCIS BEULAH NAYLOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #445 Item 27 ANTHONY FRANCIS WATSON (SON) SOI WINTERS LN. CATONSVILLE, MD Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of ₹ Greenwort (Cella) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ARBUTUS 21 4 ☐ Donation 5 ☐ Other (Specify) 06 BALTIMORE, MO 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE /aughn 5151 BAUTO. NATU PIKE, BAUTO. MO 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): 48 hours /Medical Examiner Foi Cive 24hours Peral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner ed by the attending physicien and detached for use as the burial-transit Metabolic Aciolosis that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medicai Metastatic monsmall Dura cell IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Polmonary Obstructive 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred Hospitel or Attending 1 ANatural 5 Pending 1 Yes 2 No nours after death.

nerel Director: A
filled in by the for investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. KES-000 10UPOU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STAVPOLL Sinau M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 2 5 2006 Registrar

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			For State Registrar	State of Ma	aryland .		irtment of F tificate of	lealth and N <i>Death</i>	Mental Hy	giene Reg. No.	000	12857
	1 E 4.		1. Decedent's Name (First, Middle, La			,			2. Date of De	eath Day	y Year	3. Time of Death
	Physici /Medic		+LORENC	7 WAST	TING	TON			4	2	2 200	
	Examin		4a. Facility Name (If not institution, giv				4b. City, Town, o	r Location of Death	'	4c.	County of Dea	ith
	Funeral	1	Manor Care Chevy 5. Social Security Number 6. S	iex 7. Agr	e (In yrs. last	birthday)	Chevy If Under 1 Year Months Days	Chase If Under 24 Hrs. Hours Min.	8. Date of Bi	rth	Montgon 9. Bi	rthplace (State or Foreign
	Director		130-03-9289	□м 2ᡚ F	91	Yrs.	Wioritins Days	Hours Will.	05-2	3-19	14	Canada
0	A 4		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation					10d. Inside City Limits
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ç	r 28a	lrec	10e. Street and Number				10f. Zip Code			10g. Citi	izen of What C	ountry?
di in	23a o 23a o	al D	2201 Colston Dr.	<i>#</i> 506				20910		US	SA	
Glod within 70 hours after death with the Mandand	permit. Pages I and a should be filed within 72 flouts after beath with the marylar loperation of Health and Mental Hygiene. Important: if term 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avent, the Marical Examinat must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 22☐1 If Yes, Give Year or Dates:			Vas Decedent of H f Yes, specify Cuba □ Yes 2∑No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	0-	14. Race - Am Black, Wh Specify: B	
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X	mark mark	ို	19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (Street	and Number or Rui	ral Route Numb	er, City o	r Town, State,	Zip Code)
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ָב בּ ה	of Hez		20a. Method of Disposition		20b. Plac	e of Disno	sition /Name of		Date	20c. Lo	ocation - City o	Town, State
	tment tant: It		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	y)	Che		ake Crema		-25-200	5 I	Beltsvi	lle, MD
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L the	ned by deta	by Ph	Part II. Other significant conditions of	contributing to death b	ut not resultir	ng in the ur	nderlying cause giv	en in Part I.	23e. Did	tobacco u	ise contribute i	to the cause of death?
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	After funer	tlon	27. Manner of Death 1 S Pending 2 □ Accident investigatio	28a. Date of Injur (Month, Day	y Year) 28	b. Time of Injury	28c. Injur Wor	yat k? Yes 2 □ No	28d. Describe	how infur	y occurred	
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5 3	rs afte al Dire ed in t	Certification:	4 Homicide	building, etc	с. (Ѕресіту)				City or To	wn, State)	
200	to the hospital or Attending Priystotatt. The law within 24 hours at cleath. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 to	edical	29a. Certifier (Check only one) 1. ☐ Certifying Photostal Exer	nysician: To the best of miner: On the basis of and manner sta	f examination	dge, death and/or inv	occurred at the tire restigation, in my o	me, date and place, ppinion, death occur	, and due to the rred at the time,	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)
F	To the	Σ	29b. Signature and title of certifier	250			29c. Licens			29d. Dat	te signed (Mon	th, Day, Year)
	/		,					192426	6	4/2	4/06	1
	15		30. Name and address of person who					. 1 .	1. 22	772 -	5 . A . A .	0 7 . 2 6 .
	Sta	į.	Suni Ha Bhog. 31. Date filed (Month, Day, Year) APR 2 5	32. Registra	ar's Signature	e cont	JUNIO R	road su	14 050,	1000	301V, M	11-12/6.
	Registr		APP 9 5	2006	w A	A						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No 2. Date of Death 3. Time of Death **Physician** 2006 0126 M Apri /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number). 4b, City, Town, or Location of Death Examiner 115 OWN Sa hWes Imore a 0 0 land Year If Under 24 Hrs. If Under 1 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** 1 M 2 □ F Yrs. Director 220-20-6559 27, 1928 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir than "natural", or Items 23s or 28s-f show the Medical Exerciper must be notified at 1 ☐ Yes 2 ☐ No Director N/A Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21231 U.S.A. 227 S. Bethel Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 3 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Rockland Industries Crane Operator 9th 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked other any injury or other traumatic event, sone. 17. Father's Name (First, Middle, Last) Be Elizabeth Milbourne Edward Wright Sr. Mae ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rose Mary Wright/Daughter 4107 Fox Hollow Lane Balto. MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery April28,2006 Baltimore, MD 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME
1412 E. PRESTON ST. BALTO. MD 21. Signature of Funeral Saprice Liceus re 21213 23a. Part1. Enter the disease, or complications that aused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final schemic **Physician** OVOIL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The taw requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detected. that initiated events resulting in death) Last Due to (or as a consequence of): O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Inknown 24a. Was an autopsy perform 24b. Were autopsy lindings available prior to completion of cause of death?

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Registrar

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32 Registrar's Signature

30 Name and address of person who completed cause of death (Item 21a) (Type, Print

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31. Date filed (Month, Day, Year)

		1- State of Man		artment of Health an rtificate of Death	nd Mental Hy	giene Reg. No. 006	12859	
Dhuaisi	1. Decedent's Name (First, Middle, Last) Physician				2. Date of De	eath Day Year	3. Time of Death	
/Medic		Walter Stanislaus N		April	20,2006	11:55 P M		
Examir	er	4a. Facility Name (If not institution, give street and number) Harborside Health Care		City, Town, or Location of Death		4c. County of Death N/A		
Funeral			In yrs. last birthday)	Baltimore Cit	Hrs. 8. Date of Bir		rthplace (State or Foreign	
Director		215-12-9784 ^{1⊠M 2□F}	84 Yrs.	Months Days Hours	Min. (Month, Da 10/22/		timore, MD	
and		Usual Residence of Decedent 10a, State 10b, County 1	0c. City, Town or Lo	cation			10d. Inside City Limits	
should be filed within 72 hours after death with the Maryland and Mental Hygiene. In arked other than "natural", or items 23a or 28a-f ehow umetic event, the Marical Exercitor Land be inclified at	to	Maryland N/A Baltimore 1√XY es 2□No						
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2 sho and h	ľ					Rural Route Number, City or Town, State, Zip Code)		
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permit Pages I and 2 should be filed within 72 hoperment of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "naturely or other treumetic event, Item "naturente."		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	cemetery, cren	natory or other place)		•		
mit. P partme portan r injur		4 Donation 5 Other (Specify) Holy Rosary Cemetery 04/24/2006 Baltimore, Maryland 21. Signatural Funeral Schice Licensee Charles F. Miner 22. Name and Address of Facility Baltimore, Maryland 21214						
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		23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line:					Approximate Interval Between Onset and Death	
Physician /Medical		disease or condition resulting in death) a. Aspiration Muleoner						
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		Danen '		D 30001		HROW &!	1200	
10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ballingle Hd - 21239						
Sta Regist		31. Date filed (Month, Day, Year) APR 2 5 2006 32. Registrar's	Signature	de		-		

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WOODSON, CLARK

physician:

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Name

Maryland 21215-0036

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Division of Vital Records,

			For State Registrer	State of Maryla		artment of H			ene 0 0 6	12861
			1. Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physici		Robert Allen	Young				Month April	20, 200	1.1
1	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	APLII	4c. County of D	
	Exami	CI	5 Plancent Pides 1	Drive Ant D	1 /4				Balti	
-	Francis		5 Pleasant Ridge 1			If Under 1 Year	gs Mills If Under 24 Hrs.	8. Date of Birth		
н	Funeral Director		10	M 2□F 85	Yrs.	Months Days	Hours Min.	(Month, Day, Y Jan. 16,	(ear)	Birthplace (State or Foreign Country) Texas
			466-03-0277 Usual Residence of Decedent				L	Jan. 10,	1721	Texas
	dand ow		10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	Mary	ō	MD Daladaa		0	- M411-				1 ☐ Yes 2√ No
	288 288	Director	MD Baltimo	re	OWING	s Mills 10f. Zip Code		100	. Citizen of What	Country?
	with so a	ā								,-
	eath	Funeral	5 Pleasant Ridge	<u>Porive Apt.</u> 12. Was Decedent Ever in U		21117 Was Decedent of H	ienanio Origina (Sa	onify Voc or No	USA 14 Baco - A	merican Indian,
	er de litem	n	The state of the s	Armed Forces?	J.J. 13.	If Yes, specify Cuba	in, Mexican, Puerto	Rican, etc.)		/hite, etc.
36	s aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify:	TT1 *
5-0036	hour	ğ			16a Dasa	dent's Usual Occupa	-ti	46	the Mind of Business	White
Ċ	"na"	Completed	15. Decedent's Edu (Specify only highest grad	completed)	(Give	kind of work done of DO NOT use retired	during most of work	ing	b. Kind of Busine	ess/industry
2121	within and the man	μ̈́	Elementary/Secondary (0-12)	College (1-4or 5+)						4 1 1
	be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "natural" or Items 23a or 28a-1 show event. The Madical Examinar must be notified at	ပိ	17. Father's Name (First, Middle, Last)	5	Forei	gn Servic		e (First, Middle, Ma	Foreig	n Ald
ī	be d d d	Be	17. Father's Name (First, Middle, Last)				TO. MOUTHER'S NAME	e (Filst, Middle, Ma	oven Sumame)	
Ž	should be land Mental I s marked o	P	Henry Young		11			a Unzick		
Maryland			19a. Informant's Name/Relationship (Ty	oe, Print)	19b. Maili	ng Address (Street a	and Number or Rur	al Route Number, (City or Town, Stat	e, Zip Code)
	1 and 2 Health tem 27 other tr		Rawdon Young	Son	1021	Arlingto				VA 22209
ore	es 1 ar of Hea fitem r othe		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ P		Place of Dispo cemetery, cre	osition (Name of matory or other place		Date 20	c. Location - City	or Town, State
Ĕ	Pages nent of ent: If it ury or o		`4 □ Donation 5 □ Other (Specify)		rroll (Cremation	4/21	/06	Hampste	ead MD
altimore,	permit. Pages Department of Importent: If i any injury or one		21. Signature of Funeral Service License			2. Name and Addres			*	town Road
m	Depar Impo any ir		Stephen M.	Jankins		Eline Fun	eral Home			MD 21136
			23a. Part1. Enter the disease, or compli	cations that caused the dea						Approximate
	-		shock, or heart failure. List only or Immediate Cause (Final	e cause on each line.		THE COMPANY OF THE CO				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as conse	myel	un				
В	Examiner			CINAL F	ililica					
		ē	Sequentially list conditions,	Due to for as a conse	quence of):					
	ted	nin	Cause (Disease or injury							
	xecu and II-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a conse	quence of):					
8760	The law requires that the death certificate be executed to has been signed by the attending physician and lage 2 should be detached for use as the buriat-transit	<u>e</u>								
87	phys the	dical								
9 ×	eath certific attending p	Physiclan/Med	IF FEMALE:	3c. If yes, outcome of pregn	2004					
Box	ath c	an	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fet	al death 3	Ectopic pregnancy			23d. Date of Month	delivery Day Year
	e de the a	Sic	1 Yes 2 No	4 Pregnant at time of 9 Unknown	death 5	Other (specify)				
0.	at th	Phy						an Bidash		
Ś	res that the de signed by the a l be detached t	by	Part II. Other significant conditions cor		suiting in the u	inderlying cause give	en in Part I.			e to the cause of death?
Records,	w require been sign	Completed	110310	ite cancer				1 ☐ Yes	2 No 3 □	Probably 4 Unknown
SC	has be	ple	·					24a. Was an autopsy	24b. Were	autopsy findings available to completion of cause of
	The rate has page	ПО						performe	d? death	1?
Vital	icien: Th certificate rector, pag	a	25. Was case referred to medical				26. Place of Deat	h (Check only one)		
	S 0 10	o B	examiner?	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 DOA Othe			e 6 Other (S	pecify)
Division of	g Ph er thi	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injury Work	at	28d. Describe how		
o	tending Ph leath. tor: After th the funeral	tlo	1 Natural 5 Pending 2 Accident investigation	(Month, Day 16ar)	Injury		Yes 2 □ No			
<u> </u>	f or Attendi after death. Director: A in by the fu	fice	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	nome, farm, sti	reet, factory, office				Rural Route Number,
á	after after Dire	Certification:	4 Homicide	building, etc. (Speci	ify)			City or Town,	State)	
	spite ours neral		29a. Certifier 1 Certifying Phys	icien: To the best of my kn	owledge, deat	h occurred at the tim	ne. date and place.	and due to the cau	se(s) and manner	as stated.
	To the Hospitef or Atwithin 24 hours after d To the Funeral Direct	edical	(Check only 2 Medicel Exeminate)	er: On the basis of examin and manner stated.	ation and/or in	vestigation, in my or	pinion, death occur	red at the time, date	and place, and o	due to the cause(s)
	o thin o thin o thin o thin o thin o thin o thin o mpl	₩	29b. Signature and title of certifier		·	29c. License	number	29d	. Date signed (Me	onth, Day, Year)
	⊢s⊢ō		MALLO ANIA	where V	CO	000	60680		04/21	2006
	1				- 02-) (7:	Deins	+		7.120	
5	(30. Name and address of person who co	MICHPIC	11 20a) (1ype,	Main	St. Kell	terstone	1,MD	21136
	Sta	to	31. Date filed (Month, Day, Year)	32 Registrar's Sign	ature 🖊	V 10111		,	/	
	Registr		APR 2 5 200	mpleted cause of death (Ite . MICNESS A Registrar's Sign	T. Ago	346				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Maryla	•	artment of F rtificate of		, ,	ene g. No. 0 0 6	12862
100	Dhysiai	0.10	Decedent's Name (First, Middle, Last)			·		2. Date of Death		3. Time of Death
	Physici /Medio		Vivian to	ung		T		April	17 2000	
4-	Examir	er	4a. Facility Name (If not institution, give			1	or Location of Dea LUDDE	th	4c. County of Deat	h
3		, ·	5. Social Security Number 6. Sec	7. Age (In vi	rs. last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birth	N A	holace (State or Foreign
100	Funeral Director			M 218 79	Yrs.	Months Days	Hours Min		Year) Co	hplace (State or Foreign untry)
	p.		Usual Residence of Decedent					100.70		
	anylau show	5	10a. State 10b. County		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the M	ecto	MD N N	BA	UTIMORE			10	g. Citizen of What Co	
	with Se or	Dir	0	OAD		10f. Zip Code	_		g. Cilizen di What Co USA	untry?
	death me 20	Funeral Director		12. Was Decedent Ever in		21230 Was Decedent of F	tispanic Origin? (5	Specify Yes or No-	14. Race - Ame	
ထ္	or its		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		If Yes, specify Cub: 1 ☐ Yes 2 🗷 No		to Rican, etc.)	Black, White	e, etc.
8	ural',	d by	3 ∰Widowed 4 □ Divorced	Year or Dates:					Specify: BL	ACK
21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or iteme 23e or 28e-f show the Medical Exercise roual be rotified at	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wo	rking 1	6b. Kind of Business/	Industry
12	withii ene. than	dino	Elementary/Secondary (0-12)	College (1-4or 5+)	1	MEMAKER			DOMESTIC	7
	illed Hyg other	BeC	17. Father's Name (First, Middle, Last)					me (First, Middle, M		
/lar	uld be Menta Irked rice	ToB	LEE STAPLES				ARDELIA	THOMPSO	M	
Maryland	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23e or 28a-1 show may injury or other traumatic event, the Medical Examinat must be notified at once.		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Maili	ng Address (Street	and Number or R	ural Route Number,	City or Town, State, 2	Zip Code)
	end lealth m 27 her tr		DOLLEEN YOUNG (DAUGHTER)		NORLAN	D RD. 1	BALTO. MO		
Baltimore,	intoff intoff interestriction		20a. Method of Disposition 1 D +Burial 2 □ Cremation 3 □ F	lemoval from State	cemetery, crea	osition (Name of matory or other pla	' 1		0c. Location - City or	Town, State
Ē	rtmer rtant njury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		140. NA				AUD. MD	
Ba	Depa Impo sny i			7				UNERAL S		
¥.,	* 1		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused the de					MD 21229	Approximate
	Physician		Immediate Cause (Final disease or condition	D						Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a cons						2 days
	Examiner		Sequentially list conditions.)						
	sit ad	iner	Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for as a cons	equence of:					
_	and and II-tran	Examin	that initiated events resulting in death) Last	Due to (or as a cons	equence of):					
8760,	icate be executed physicien and s the burial-transit	dicai E							1	
.89	ifficati g phy as the	edic								
Вох	th cer tendin r use	Physician/Me	230. Was decedent pregnant	3c. If yes, outcome of pred		Ectopic pregnancy	v		23d. Date of del	•
о. В	e dea he att	sicia	in the past 12 months?	4☐ Pregnant at time of		Other (specify)			Month	Day Year
P.	The law requires that the death certifi tite hes been signed by the attending page 2 should be delached for use as	Phy	9 ☐ Unknown Part II. Other significant conditions con		regulting in the u	ndashing anusa su	on in Boot!	220 Did tobe	acco use contribute to	the equal of death?
Vital Records,	signe d be	d by	atti. Salar signilisani sonaniono son	inibating to doubt but not	osulling in the d	noonying cause giv	out iit rout i.	1 ☐ Yes		obebíy 4 Dunknown
Ö	w requir been si should	Completed						24a. Was an		topsy findings available
Re	The lar	dinc						autopsy perform	ed? prior to death?	completion of cause of
tal		Be C	25. Was case referred to medical			We .	26 Place of De	ath Check only one		2□ No
\leq	S S 5	ToB	examiner?	lospital: 1 Inpatient 2	☐ ER/Outpatier	nt 3 DOA Oth	100		ice 6 Other (Spec	cify)
n of			27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year,	28b. Time o	f 28c. Injur Wor		28d. Describe how		
Sio	Attending r deeth. ector: Afte by the fune	catle	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No			
Division	or Attenualter deet Director:	Certification;	4 Homicide determined	28e. Place of Injury - Albuilding, etc. (Spe		reet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	iral Route Number,
	To the Hospital or Attent within 24 hours after deeth To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Phys	sician: To the best of my k	nowledge dest	h occurred at the te	me date and place	and due to the co-	ica(c) and massac	etatad
	the Hospital hin 24 hours at the Funeral upletely filled	Medicai	(Check only 2 Medical Examination)	ner: On the basis of exam and manner stated.	ination and/or in	vestigation, in my o	ppinion, death occi	urred at the time, dat	e and place, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	\		29c. Licens	se number	29	d. Date signed (Monti	n, Day, Year)
)	6		Caltainin	Dutha	MD	RES	100		April 17	2001
Ć			30. Name and address of person who co	impleted cause of death (I	tem 23a) (Type,				Raltine	, , , , , , , , , , , , , , , , , , , ,
)		Catherine G	1.45.2	3001	South 1	marshall	Sweet	Baltino	ce, MO
	Sta		31. Date filed (Month, Day, Year) APR 2 5 200	Registrar's Sig	Indiane And	ALP B				

			1 - For State Registrar	State	of Marylar	-	artment of I rtificate of		nd Mental H	9	11116	12863
			Decedent's Name (First, Mi	ddle, Last)			tineate or	Death	2. Date of	Reg. No. Death	.000	3. Time of Death
п	Physicia		Nathaniel	C.	ALLE	NI JR			Month	Day		0001 M
	/Medic Examin		4a. Facility Name (If not institu			, , , ,	4b. City, Town, o	or Location of			County of Death	0001
			Howard Co	unfy GE	neral 1	Hospit	as co	· lumbi	a		HEWAI	d
	Funeral		5. Social Security Number	6. Sex 1X□M 2□F	7. Age (In yrs.	**	If Under 1 Year Months Days	If Under 24 Hours		Birth Day, Year)	9. Birtho	olace (State or Foreign
	Director		230-64-9859 Usual Residence of Decedent		59	Yrs.			April	29, 1		rginia
	yland		10a. State 10b. Cou	nty	10c. Ci	ty, Town or Lo	cation				1	0d. Inside City Limits
	a-f st	tor	Maryland Hov	vard	Lau	rel						1 ☐ Yes 2 🙀 No
	or 28.	Director	10e. Street and Number				10f. Zip Code			10g. Citi	izen of What Cour	ntry?
	ath w	rai	8621 Flowerin	g Cherry	Lane		20723			ı	USA	
	teme teme	Funerai	11. Marital Status	Armed	ecedent Ever in U Forces?	.S. 13. \	Was Decedent of I f Yes, specify Cub	dispanic Originan, Mexican,	n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Americ Black, White,	
36	d within 72 hours after death with the Maryland yiene. r than "natural", or Iteme 23a or 28a-f show the Medical Examiner must be mutified at	by Fi	1 Never Married 2 1 Nover Marr	If Yes	s 2□No Give Dates: 1967		1 ☐ Yes 2 🛣 No			1	SpecifyBlac	
21215-0036	2 hou	ed		lent's Education	Dates: 1907		lent's Usual Occur	pation		16b Kir	nd of Business/In	dustry
215	within 72 ene. then "ru he Med	Completed	(Specify only hig Elementary/Secondary (0-1)	hest grade complete	d) (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most o	f working			addity
7	giene giene	E O	Elementary/decondary (o-1)		4	Build:	ing Maint	cenance	Engineer	r Fe	ederal G	overnment
pu	be filed tal Hygi d other event, I	Be (17. Father's Name (First, Midd					18. Mother's	s Name (First, Midd	lle, Maiden	Sumame)	
<u>₹</u>	Men	မှ	Nathaniel Cl		en			l	leline Jac			
Maryland	d 2 sh th and 7 ls n traun		19a. Informant's Name/Relation Deborah E. A		9				or Aural Aoute Num ry Lane,			
<u>ق</u>	1 an Heall tern 2		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of	7	Date		cation - City or To	
Baltimore,	permit Pages 1 and 2 should be filed w Department of Health and Menial Hygier Important: If Item 27 Is marked other it any injury or other traumatic event, In		1 ☑ Burial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other		ii State		natory or other pla Memorial G	1 **	oril 8, 2006		iottsvil	
i i	mit Postrario		21. Signatural Funeral Serv	11 21	020				ns Funera			ite, MD
Ď	\$ 9 E E 8		Nobert	()/W		50	cancıs J. 00 Univer	colli sity E	ns Funera Slvd, W, S	al Hom Silver	ne Inc. Spring	, MD 20901
			23a. Part1. Enter the disease shock, or heart failure. I	or complications that ist only one cause or	t caused the deat	h. Do not ente	er the mode of dyin	ng, such as ca	rdiac or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Ad	164 RP	Spira-	toru 1	21/2 to	ess Syl	dros	on e	Onset and Death
	/Medical Examiner		resulting in death)	Due t	o (or as a conseq	uence of):						93
		2	Sequentially list conditions, if any, leading to immediate	b. Due t	O (of as a conseq	manon off:						vons
	nsit	nine	cause. Enter Underlying Cause (Disease or injury	₹	n Oum ex	,						10-
<u>,</u>	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	c. Due t	o (or as a conseq							rans.
8760,	cate be executed physician and the burial-transit	dlcat		d								
9		Med	IF FEMALE:									
Š	death certif e attending of for use as	an/	23b. Was decedent pregnant in the past 12 months?		utcome of pregna birth 2 Peta		Ectopic pregnancy	,		2	23d. Date of delive	,
O.	that the death certif ed by the attending detached for use a	by Physician/Me	1 Yes 2 No	4□Pre 9□Uni	gnant at time of d		Other (specify)				Month	Day Year
<u>a</u> .	that the ed by detac	F.	Part II. Other significant cond	itions contributing to	death but not res	ulting in the ur	odertving cause an	ren in Part I	23e Dir	1 tobacco us	se contribute to th	e cause of death?
ds,	Physician: The law requires that the this certificate has been signed by the rail director, page 2 should be detached.		Asbest				denying occording	Girari Cate.		Yes 2		/
S	w req	lete							24a. We	10.00	24h Mora auto	nov findings available
Be	he la e has age 2	Completed	8						aut	opsy formed?	death?	osy findings available impletion of cause of
tal	an: Tifical	0	25. Was case referred to med	cal				26 Place of	1 Yes Death Check only		1 ☐ Yes	2 A No
>	ysicl is cer direc	10 B	examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1	Inpatient 2	ER/Outpatien	3 DOA Oth	000	ng Home 5 □ Re		S □ Other (Specifi	<i>'</i>)
0	ding Physician: The lav h. After this certificate has funeral director, page 2		27. Manner of Death 1 ■ Natural 5 □ Pen		e of Injury onth, Day Year)	28b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe	how injury	y occurred	·
sio	tendi leath. tor: A the fu	cati	2 ☐ Accident inve	stigation			M 1 🗆	Yes 2 □ No				
Division of Vital Records, P.O. Box	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	4 Homicide dete	mined 200 Pla	ce of Injury - At he ding, etc. (Specif	ome, farm, stre y)	eet, factory, office			(Street and own, State)	d Number or Rura)	l Route Number,
_	spital ours neral filled		29a. Certifier 1 Certif	ying Physician: To t	he hest of my kno	wledge death	occurred at the tir	ne date and	place, and due to th	e causo(s)	and manner as et	atad
	P Full	edicai	(Check only 2 Medic one)	al Examiner: On the	basis of examina	tion and/or inv	estigation, in my o	pinion, death	occurred at the time	e, date and	place, and due to	the cause(s)
	To the within To the Comp	Me	29b. Signature and title of cert	fier			29c. Licens	e number		29d. Date	e signed (Month,	Day, Year)
i i	411		Hours	dian			142	892		APR	03	2006
4			30. Name and address of pers	on who completed ca	use of death (Item	n 23a) (Type, i	Print)	,				4.
<u> </u>			Francis Ch 31. Date filed (Month, Day, Ye	uidian	1072 Pagistra 5	4 61	me Pa	tuxent	r Parler	verag	Calamp	IG IND
	Stat	æ		0 2006	ogistat s Signa	A Mag	All)					~1079

			For State	State of Ma		epartme	ent of He	ealth ar		-		106	12961
			Registrar			Certifica	ate of L	Jeath			g. No.	IUU	12004
Ž,	Physici	an	Decedent's Name (First, Middle, Last,			_				Date of Death Month	Day	Year	3. Time of Death
	/Medic	_	Robert	E.		Boyds		4		March	31	2006	10:25 a ^M
	Examin	er	4a. Facility Name (If not institution, give				ty, Town, or roftor		Death			ounty of Deat	
7.		et by	Crofton Convales 5. Social Security Number 6. Se		e (In yrs. last birt		der 1 Year	.1 If Under 24	4 Hrs.	8. Date of Birth		ne Art	
*	Funeral Director			X M 2□F	_	Yrs. Month			Min.	(Month, Day,	Year) 191	9 Arl	hplace (State or Foreign untry) Cansas
	and and		10a. State 10b. County		10c. City, Town	or Location							10d. Inside City Limits
	Mary 1 eh	ţo	MD Anne Ar	undel	Odent	on							1 ☐ Yes 2 No
	r 28a	Director	10e. Street and Number		1	10f.	Zip Code			10	g. Citize	n of What Co	untry?
	h with	al D	1194 Winer Road				2111	13			US	A	
	deat	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was De			n? (Spec	cify Yes or No- lican, etc.)		Race - Ame Black, White	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hydiene. Department of Health and Mentall Hydiene. If item 27 is marked other then "natural", or items 23a or 28a-f show eny injury or other traumatic event. The Medical Exemplar minal be notified a once.	by Fu	1 Never Married 2 Married 3 XWidowed 4 Divorced	1 XYes 2 ☐ I If Yes, Give	No	1 ☐ Yes		Specify:		, 515.7	S		Thite
Ö	hour tural	q pe	15. Decedent's Edu	Year or Dates:	1937-67	Decedent's U	sual Occupa	tion			ISh Kind	of Business/	Industry
5	in 72	olet	(Specify only highest grad	e completed)		(Give kind of life. DO NO	work done di	urina most o	of workin	g	100.11410	01 000111000	
212	y with	Completed	Elementary/Secondary (0-12)	College (1-4or 5	0+)	Analys	t				N	ISA	
ğ	ntai Hygie ad other event.	Bec	17. Father's Name (First, Middle, Last)		•			18. Mother's	s Name	(First, Middle, A	faiden Su	ımame)	
<u>lar</u>	uid b Venta rrked ric e	To E	Eugene Boydstun					Ве	ss (Carse			
Maryland 21215-0036	2 should and Men ie marke eumatic		19a. Informant's Name/Relationship (T)							Route Number,			(ip Code)
	l and lealth m 27		John Boydstun (B	rother)	The second second second				-	/isalia,			Taum State
Baltimore,	Pages 1 nent of H nnt: if ite ury or ot		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ F		20b. Place of cemeter							tion - City or	
Ξ	it. Pa		4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licens		Maryla	ind Vet	and Address		-6-2	2006	rown	sville	e, MD
Ba	permit. Departr importa eny inju		21. Signature of Fulleyal Service Licens			Har	desty	Funer	al F	Home, P.	A.	MD 01	401
71			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ications that caused	the death. Do r					Annapo respiratory arre		MD 21	Approximate
4 1	Physician		Immediate Cause (Final	ne cause on each li									Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. LOYONLY Due to (or as	a consequence	ry de	leade	,					
	Examiner			_		7							
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	of):							
	nd ransi	Examiner	Cause (Diseese or injury that initiated events resulting in death) Last	c									
760,	te be executed ysicien and e burial-transit		resulting in death) cast	Due to (or as	a consequence	of):							
687	9 % 9	dlcal		d									
9 ×	ding	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy						23/	d. Date of deli	NACV
Вох	that the death certificate ed by the attending physi detached for use as the	clan	in the past 12 months?		2 Fetal death	3 □Ectopii 5 □ Other	pregnancy (specify)				250	Month	Day Year
o.	the d y the sched	lsk	1 Yes 2 No 9 Unknown	9☐ Unknown									
o.	Attending Physicien: The law requires that the death certifical croad. Crobath. Color: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the	by Physician/Med	Part II. Other significant conditions co	ntributing to death b	ut not resulting ir	the underlying	g cause give	n in Part I.		23e. Did tob	acco use	contribute to	the cause of death?
rds	w requires that been signed to should be det	ed b								1 ☐ Ye	s 200	No 3□Pr	obably 4 Unknown
Vital Records,	aw re	Completed								24a. Was ar		24b. Were au	topsy findings available
ž	The law ate has l page 2 s	E O								perform	ned?	death?	
ta	striffica ctor,	Be	25. Was case referred to medical examiner?						of Death	(Check only on	(
× ×	hysic his co	2	1 ☐ Yes 2 💢 No	Hospital: 1 ☐ Inpatie			DOA Othe	Nurs		ne 5 🗆 Reside			cify)
ū	Alter I	ü	27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b. 1	Time of njury	28c. Injury Work	? _		8d. Describe ho	w injury o	occurred	
Sic	ttend death tor: /	cat	2 Accident investigation 3 Suicide 6 Could not be	29a Place of Ini	uar Athama fa	M m street for	1	′es 2∐No	-	8f Location /St	met and l	lumbas os D	ıral Route Number,
Division of	or All	Certification:	4 Homicide determined	building, et	ury - At home, fa c. (Specify)	rm, street, rac	тогу, опісе		2	City or Town	, State)	vuiliber or Ac	ra: Houle Number,
	e Hospital or Attending I 24 hours after death. • Funeral Director: After etely filled in by the funer		29a. Certifier 1 Certifying Phy	sician: To the best	of my knowledge	, death occur	ed at the tim	e, date and	place, a	nd due to the ca	use(s) ar	nd manner as	stated.
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	(Check only 2/ Medicel Exami	ner: On the basis o and manner st	f examination an	d/or investigat	ion, in my op	inion, death	occurre	d at the time, da	ite and pl	ace, and due	to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier				29c. License			25	d. Date s	signed (Monti	h, Day, Year)
}			· WIM	MI	2		D389	158		3	131	106	
			30. Name and address of person who c	ompleted cause of	eath (Item 23a)	(Type, Print)	1, -,		0	00 n			
100	-2 or \$ 1		31. Date filed Month, Day, Year	h sellh	ar's Signature	crain	Mighu	ouy S	SW	Olin B	umu	e MI	21061
	Sta Registi			06	- B	Shoots		V					

State of Maryland / Department of Health and Mental Hygiene Rag. No. 006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April **Physician** 223fm 2006 Bruce Brotherton Blair /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cify, Town, or Location of Death 4c. County of Deeth Examiner Washington County Hospital Washington Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1X M 2□ F Months Days Director 220-28-2843 74 Feb. 26, 1932 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ı ıs marked other then "naturel", or thems 23a or 28a-f sho treumatic event, the Madical Examinar must be notified at 1 Yes 2 □ No Funeral Director Maryland Washington Clear Spring 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code 157 Cumberland Street 21722 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🛛 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dockman Trucking 8 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked other any injury or other treumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ George Brotherton Blair Laura Helen Drury 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 342 Jefferson St. Hagerstown, MD 21740

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City <u>Vikki Brown - Daughter</u> 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery April 11,2006 Clear Spring, Maryland 21. Signatur of Funeral Service License, 22. Name and Address of Facility Osborne Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Gastrointestinal Bleeding Few Day Division of Vital Records, P.O. Box 68760, al Ulcer Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Diabetes Mellitus II ģ 24b. Were autopsy findings aveilable prior to completion of cause of deeth? Hypertension 24a. Was an autopsy performed? Be Completed Conty Artheitis 1 ☐ Yes 2 No 25. Was case referred to medical exeminer?
1 XYes 2 □ No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation s after dea... al Director: After 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be determined To the Hospital or Atter within 24 hours after de To the Funeral Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) (Alacha Mi) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. PASHA. MD 1122 OPAL CT. HAGERSTOWN MD 21740 WH-3 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

			For State Registrar	State of	Maryland / De	partment o ertificate d			,	jiene	16	12866
п	Physici		1. Decedent's Name (First, Midd		. 1				2. Date of Dea Month APRIL	Day	Year	3. Time of Death
	/Medic	al	Frederick Alfo 4a. Facility Name (If not institutio			4b City Tow	vn, or Locatio		APKIL		y of Death	
	Examin	er	Washington County		5.7	15. 5.19, 15.1		stown				County
	Funeral Director		5. Social Security Number 214–09–9677		Age (In yrs. last birthda 86 Yrs.	y) If Under 1 Y. Months Da		er 24 Hrs.	8. Date of Birth (Month, Day Oct. 17	Year) 1919	9. Birth Cou Mary	place (State or Foreign intry) cland
	and		Usual Residence of Decedent 10a. State 10b. County	v	10c. City, Town or	Location						10d. Inside City Limits
	r 28a-f show	tor		ngton	Haos	erstown						Y∏Yes 2 No
	ilied within 72 hours after death with the Maryland Hygiene. ither then "natural", or Iteme 23a or 28a-f show int, the Medical Examination must be motified at	Funeral Director	10e. Street and Number 346 West Side Av			10f. Zip Co	_{de} 1740			10g. Citizen of U.	What Cou	intry?
	eme 2	nera	11. Marital Status	12. Was Decede	ent Ever in U.S. 1	3. Was Decedent If Yes, specify (of Hispanic (Origin? (Spe	cify Yes or No-		ce - Ameri	ican Indian,
36	rs after des I', or Iteme	by Fu	1 ☐ Never Married 2X Mar 3 ☐ Widowed 4 ☐ Divorced	rried 1X Yes 2	□ No 2-5-43	1 ☐ Yes 2 🔀			,,	Speci		hite
Maryland 21215-0036	12 should be filed within 72 hours in and Mental Hygiene. 7 is marked other than "natural; traumalic event, the Medical Exa			nt's Education est grade completed)	16a. De	cedent's Usual Or ve kind of work de	one durina m	ost of working	ng	16b. Kind of E	dusiness/lr	ndustry
121	within ane. than "	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	DO NOT use re Dwner	etired)			Rest	aurant	-
d 2	Hygie Hygie other ent, II	ပိ	17. Father's Name (First, Middle,	, Last)		MEL	18. Mo	ther's Name	(First, Middle,			
/lan	uld be Vental Irked c	To Be	Frederick Alfor	nso Burger, Sr	•			Mabel	Ruth Bar	ber Burg	er	
Aan	2 sho		19a. Informant's Name/Relations		1	illing Address (St						p Code)
	1 and Health em 27		Cleo L. Burger 20a. Method of Disposition	(Wife)	20b. Place of Dis	West Side		-	own Mary.	Land 217 20c. Location		own, State
E I	Pages tent of int: If It		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5			rematory or other on Ceneters		4–15-	-2006	Hagerst		
Baltimore,	permit. Pages 1 and 2 should by Depurment of Health and Menta Important: If Item 27 is marked any injury or other traumatic element.		21. Signature of Funeral Service		1211	22. Name and A						
	Physician /Medical Examiner		23a. Part1. Enter the disease, o shock, or hear failure. Lis Immediate Cause (Final disease or condition resulting in death)	t only one cause on eac	brovasc	ular	acc	ide	nt			Approximate Interval Between Onset and Death Approximate
8760,		licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1	as a consequence of):	otic i	card	10 Va s	cular	disea	e	25 years
P.O. Box 6	Attending Physician: The law requires that the death certificate be executed reach. rector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live birt	nt at time of death	3 □Ectopic pregn 5 □ Other (specif					ate of deliv	rery Day Year
	w requires that been signed b should be deta	þ	Part II. Other significant condition	sion			e given in Pa	rt I.	23e. Did to	. /		the cause of death?
Division of Vital Records,	The law re cate has be page 2 sho	Completed	Congestive	e Heart	Failure	<u>-</u>			24a. Was a autop: perfor	sy	Were auto prior to co death? 1 \(\text{Yes}	opsy findings available ompletion of cause of
/ita	sician: Th certificate irector, pag	Be	25. Was case referred to medica examiner?					ace of Death	(Check only or	7e)		
of	Physic this cral dir	: 10	1 ☐ Yes 2 No 27. Manner of Death		patient 2 ☐ ER/Outpar				ne 5 Resid			ify)
lon	nding f th. :: After e funer	atlon	1 Natural 5 ☐ Pendi	ing 28a. Date of (Month, tigation	Day Year) Injur		Injury at Work? 1 🗆 Yes 2					
Divis	or Attendated after death Director: A	Certification:	3 ☐ Suicide 6 ☐ Could	mined 206. Flace 0	f Injury - At home, farm, etc. (Specify)	street, factory, of	fice	2	28f. Location (S City or Tow		ber or Rur	al Route Number,
_	Hospita 4 hours Funeral	Medical C	29a. Certifier (Check only one) 1 Sertifyi 2 Medica	ing Physician: To the bas I Examiner: On the bas and manne	is of examination and/or	eath occurred at the investigation, in a	he time, date my opinion, d	and place, a leath occurre	and due to the ded at the time, o	ause(s) and m late and place	anner as s , and due t	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certific	er /	/	29c. Li	cense numbe	er	2	29d. Date sign	ed (Month,	Day, Year)
		1	Jeorge	C. Ikion	roup M-D,	ChD !) 1.	759	1	toril 1	2,2	006
OF	1-4+1		30. Name and oddress of person	an 1111	of thath (Item 23a) Typ	De, Print)	Jeun li	2 d.	1+78.	Mil a	:174	10
	Sta	te	31. Date filed (Month, Day, Year	7) 32. Rec	gistrar's Signature	1 4.	Jun 1		17			
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			For State Registrar	S			d / Dep		t of H	lealth a		ental Hyg	iene	128	67
			Decedent's Name (First, Middle)	lle. Last)								2. Date of Dea	-	3. Time	of Death
	Physicia	an	LOIS RR	AN	\mathcal{C}							Month M.ARGH	29 200 Yes	6 9:0	+S AM
	/Medic	47	4a. Facility Name (If not institution			er)		4h City	Town or	Location	of Death	ТОТТОР	4c. County of D	<u> </u>	
	Examin	er	LAVER REGI					1	100				Prince		ك
		1	5. Social Security Number	6. Sex		Age (In yrs. Ia	ast birthday	If Under	1 Year	If Under	24 Hrs.	8. Date of Birth (Month, Day		Birthplace (State Country)	
and the second	uneral irector		579-32-1367 Usual Residence of Decedent	1 □ M		80	Yrs.	Months	Days	Hours		Month, Day, Februar		New Yor	
land	A II		10a. State 10b. Count	/		10c. City	, Town or L	ocation						10d. Inside (City Limits
Mary	투경	jo	Maryland Mon	tgomei	cv		Silve	er Spi	ing					1 XX Ye	s 2 No
the	28a	Funeral Director	10e. Street and Number	-0	· ·			10f. Zip				1	0g. Citizen of What	Country?	
¥ ×	39 01		1114 Osage St	reet					209	203			United St	atec	
death	The 2	era	11. Marital Status	12.	Was Decede	ent Ever in U.S	5. 13.	Was Deced			gin? (Spec	cify Yes or No- lican, etc.)		merican Indian,	
fter		F	1 Never Married 2 Ma	rned	Armed Force 1 Yes 2						i, Puerto R	lican, etc.)	Black, W		
036 urs a	o 'la	þ	3 ☐ Widowed 4 X Divorce		If Yes, Give Year or Date			1 Yes	2X No	Specify:			Specify:	Black	
d 21215-0036 Illed within 72 hours after death with the Maryland	atur	Completed by		nt's Education			16a. Dece	dent's Usua	I Occupa	ation	a má compleim		16b. Kind of Busine	ss/Industry_	
24 F	L Figure	ple	(Specify only high Elementary/Secondary (0-12)	- T	College (1-4	or 5+)	life.	kind of wor DO NOT us	se retired	<i>l)</i>	t or workin	g	Human Se		
21% d	1 a	М	, (,		years]	Deputy	y Chie	ef,Pı	rogra	m Ope	rations	Human Se	TATCES	
ב 🚉	oth ent	Be	17. Father's Name (First, Middle	Last)						18. Mothe	er's Name	(First, Middle, I	Maiden Sumame)		
<u>a</u>	rked	10 0	Clarence A	ugustu	ıs Bo	wles				Mab	le	Palmer			
Maryland d 2 should be file	Department or result and women rygener. Department of result and women rygener is natural; or thems 23a or 28a-f show the contracts if them 27 is marked other than "natural; or other traumatic event, the Medical Examinar must be notified at once.		19a. Informant's Name/Relation	ship (Type,	Print)	(Son)	19b. Maili	ng Address	(Street a	and Numbe	er or Rural	Route Number	City or Town, State	a, Zip Code)	
No 2	alth a		Josephus Ruck	er Bra	nic I	I	7901	Trump	s Hi	111 R	oad;U	pper Ma	rlboro,Ma	ryland	20772
Baltimore,	oth o		20a. Method of Disposition	. ==		co	ace of Disperent	osition (Nan	ne of ther plac	e)	April	ite	20c. Location - City	or Town, State	
mo age	nt: If		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (oval from Sta	110	ck Cre				200		Washingt	on, D.	C.
# #	inju		21. Sonature o Funeral Solvie	1	-	16				-		_			
ä ä	Impo eny ir	2.	(Sandal	KC		The	>	R. N.	Hor	ton (Compar	ny Mort	icians, I ashington	nc.	0011
3. 1			23a. Part1. Enter the disease, of	r complicati	ons that ceu	sed the death				_		-		Approxima	ate
	教		shock, or heart failure. Lis	t only one c				0			- 2			Onset and	atween d Death
	ysician Iedical		disease or condition resulting in death)	a		w78 6	-	LATES	M	1-45	2776				
	aminer			1	0	as a consequ								60	rys
		ē	Sequentially list conditions.	b		as a consequ									
pet	nsit	를	Satuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	≺	,		,								
60 , be execut	and al-tra	Examin	that initiated events resulting in death) Last	С	Due to (or	as a consequ	ence of):								
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687 tiflicate	phys s the			d											
X 68	ding se a:	Completed by Physician/Med	IF FEMALE:	23c.	If ves. outco	me of pregnar	ncv						23d. Date of	dolaran	
Box eath cert	atten for u	lan	23b. Was decedent pregnant in the past 12 months?		1 Live birth	n 2 □ Fetal t at time of de	death 3[☐Ectopic pr ☐ Other (sp					Month	Day	Year
O B	the	ysic	1 □ Yes 2 🔯 No 9 □ Unknown		9☐ Unknow		atii Ji	_ Ott 161 (3p	OC.119)						
Records, P.O. Bo	ed by detac	급	Part II. Other significent condit	ions contrib	uting to deat	h but not resu	Iting in the u	undertvina c	ause give	en in Part I		23e. Did tol	pacco use contribute	to the cause of	death?
ds,	De ag	J D	CONZUSTURE		_		-	, ,				1 (N) Y	es 2 🗆 No 3 🗀	Probably 4	Unknown
0	plnods	ete	CHRONIC OY					1 0.0		g		/			
e a	2 5	dr.	CHAMAIC CI	551201)(100	70200	37 40 10	1015	3/13	0		24a. Was a autops perform	y prior	autopsy finding to completion of	
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of Vita	certific rector.	Be	25. Was case referred to medic examiner?		nite I.						of Death	(Check only on	е)		
) t	this o	2	1 ☐ Yes 2 💆 No	Hosp	11 Jup		ER/Outpatie			4 🗆 140			ence 6 Other (S	pecify)	
E E	fter De	io iii	27. Manner of Death 1	ing	28a. Date of I (Month,	Day Year)	28b. Time o Injury		8c. Injury Worl			8d. Describe ho	w injury occurred		
Division of Vital Records, or Attending Physician: The law requires to the state of	death.	Certification:	2 Accident Inves	tigation				М		Yes 2					
Z A	iract iract	Ē	4 Homicide deter	mined 2	28e. Place of building,	injury - At hor etc. (Specify)	me, farm, st)	reet, factory	, office		2	8f. Location (Si City or Town	reet a <i>nd Num</i> ber or n, State)	Rural Route Nu	mber,
O ital	within 24 hours after death. To the Funeral Director: A completely filled in by the fu														
dso	une une ely fi	ca	29a. Certifier 1 Certify (Check only 2 Medica	ing Physicions L'Exeminer:	en: To the be On the basi	est of my knov s of examinati	vledge, dea ion and/or ir	th occurred	at the tim	ne, date an pinion, dea	id place, ai	nd due to the ca	ause(s) and manner ate and place, and c	as stated.	(s)
the	the I	Medical	one)		and manner	stated.									
٤	1 8	~	29b. Signature and title of certifi							e number	•		9d. Date signed (Mo		
	3)		Daniel	yan	ym				1) 50	5979	-		April 1,	ZUU6	
(gc		30. Name and address of perso			of death (Item (5724	23a) (Type - L1770	Print)	WEL	nr p	men	my (En uma A	mo Z	1544
	Sta Registr		31. Date filed (Month, Day, Yea APR 0 7 2006	bee	_	istrar's Signat		_							

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

APR 0 7 2006

32. Registrar's Signature

			1 - For State Registrar	State of M	arylan		ırtment <i>tificate</i>			and M		gien Reg. N	100	6	12869
	Dhysisi	20	1. Decedent's Name (First, Middle, Last,								2. Date of De Month	D	av)	'ear	3. Time of Death
	Physici /Medi		ROSALINE ELIZABETE								APRIL 4		006		11:30A M
	Examir	ner	4a. Facility Name (If not institution, give				4b. City, T		Location o	of Death			c. County of		
			5. Social Security Number 6. Se		o //n um	last birthday)	HURL If Under 1		if Under	24 Hrs	8. Date of Bir		ORCHE	_	
	Funeral Director			M 2₫F	81	Yrs.		Days	Hours	Min.	(Month, Da FEB • 1	v. Year	25 M	Cour	place (State or Foreign htry) LAND
			Usual Residence of Decedent	<u> </u>								,			
C	nylan how	_	10a. State 10b. County	_	10c. Cit	y, Town or Lo								1	Od. Inside City Limits
7	Be-1-	cto	MARYLAND DORCHEST	ER		HURLOC	CK.	- · · · · · ·							1 ☐ Yes 2 🕅 No
2	deeth with the Maryland me 23s or 28e-f ehow rmat be notified at	Funeral Director	10e. Street and Number				10f. Zip (10g. C	itizen of Wh		ntry?
0	e 23	eral	6645 PINE TOP ROAL) 12. Was Decedent	Ever in 11	C 12 1	Nac Dagada	216		nin2 /Cn/	odu Van as Na		US.		on Indian
	Hend Fred	-un	11. Marital Status 1 ☐ Never Married 2 ☒ Married	Armed Forces?		ĺ				, Puerto	cify Yes or No Rican, etc.)	,-	Black,	White,	etc.
036	urs a	ğ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	☐ Yes 2	No No	Specify:				Specify:	WHIT	ΓE
21215-0036	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)		16a. Deced	lent's Usual kind of work	Occupa	ition	t of worki	na	16b.	Kind of Busi	ness/In	dustry
2	ithin	nple	Elementary/Secondary (0-12)	College (1-4or	5+)	life. L	00 NOT use	retired))	01 1101111	·9	_			
2	fygier tygier her th		12 17. Father's Name (First, Middle, Last)			REALTO)K	[19 Motho	r'o Nomo	/Eimt Middle		EAL E		I.F.
anc	ntal H od ot	Be	CHOS L. REITH								(First, Middle,				
Maryland	2 should be filed within 72 hours after deeth wi and Mental Hygiene. is marked other than "naturel", or itame 23s.	2	19a. Informant's Name/Relationship (T)	roe. Print)		19b. Mailin	a Address /	Street a			Aoute Number			ate Zio	Cade)
Ma	s 1 and 2 should be filed within 72 hours after deeth with the Marylar if Health and Mental Hyglene. Item 27 is marked other than "naturel", or itame 23s or 28s-1 show other treumatic event, its Medical Examinar mark to notified at		FRANCIS J. BROGLIE		Ŋ		-				RLOCK,				
ē,	of Health of Health ltem 27 i		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name	e of	norib ,		ate		ocation - C		
Ë	Pege nent o nt: If ry or		1 Burial 2 Cremation 3 ☐F 4 ☐Donation 5 ☐ Other (Specify)	Removal from State		VETERA				/7/2	006	BEU	LAH,	MARY	YLAND
Baltimore,	permit. Peges 1 Department of H Important: If Itel any Injury or oth		21. Signature of Funeral Service Licens	211.		7.1	Name and	Addres	s of Facilit	HOME	, P. O.				
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_	To the Hospital or Attending Ph within 24 hours etler death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier tel Certifying Phy	sician: To the best	of my kno	wledge, death	occurred a	t the tim	e, date an	d place, a	and due to the	cause(s) and manr	er as s	tated.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 8 per fh 9855 5-9-06 vt. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death April Day 2006 Physician 6, JAMES RICHARD BAKER 2:50 Рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Glade Valley Nursing & Rehab. Ctr. Walkersville Frederick If Under 1 Year | If Under 24 Hrs. | Pacete of Birth | 9. Birthplace (Str. Country) | 1933 | Months | Days | Hours | Min. | Pacete of Birth | Pay, Year | 1933 | Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 √ M 2 □ F Months 220-26-5254 73 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show 1 ☐ Yes 2 ☐ No Directo Maryland Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 Georgetown Road 21793 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Korean Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) is marked other than College (1-4or 5+) Civil Servant U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Glenn K. Baker Mary Wagner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Georgetown Rd., Walkersville, MD 21793 Mary T. Baker / Wife If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pag Department Importent: It any injury o Resthaven Mem. Gardens 4/12/06 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 21. Signature of Funeral Service Licenses ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. oker 1201 NORTH MARKET ST. FREDERICK, MD 21701 23a. Part1. Enter the disease, or complications that earlied the feath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exami attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown þ s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 275 NO 3 Probably 4 Unknown 1 Tes Completed cate has been s , page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed; certificate: ise ase 31 No 2 1 No 1 Yes 1 ☐ Yes or Attending Physicien: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 EN/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After th funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident Director 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours after To the Funeral Direct To the Hospitel 16 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and tille of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar DHMH 17 Rev 1/2001 30. Name and address of person who completed cause

31. Date filed (Month,

of death (Item 23a) (Type, Print)

32. R

2006

			1 - For State Registrar	State of Maryla		artment o			_	giene Reg. Nõ.	06	128	7 1
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	<u> </u>	*	2622 Felter Lane 5. Social Security Number 6. Se	7 Age (In us	s. last birthday)	Bow If Under 1 \		Jnder 24 Hrs.	8. Date of Bir		nce Geo		e Consina
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	(_	30. Name and address of person who is	empleted cause of death (fit	em 23a) ATvoa	Printh				110	WP	100	
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	Funeral Director			.Sex 1XM 2□F	7. Age (In yr	s. last birthday; Yrs.	If Under Months		If Under Hours	Min.	Date of Birth (Month, Day,		9. Birth	place (State ontry)	or Foreign
	aryland ehow	7	Usual Residence of Decedent 10a. State 10b. County			City, Town or L	ocation				,			10d. Inside C	ity Limits
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336	be filed within 72 hours after death with the Maryland nat Hyglene. ed other than "natural", or Items 23a or 28a-f ehow event, the Madical Exartinar mast be notified at	by Funeral Director	1264 Dogwood Roa 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dec	2□No W	U.S. 13.	Was Deced If Yes, spec	ent of Hi	spanic Ori n, Mexican Specify:	igin? (Specify n, Puerto Rica			lace - Amer lack, White	can Indian,	
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and	ould be fited Mental Hygi arked other atic event, ii	To Be (17. Father's Name (First, Middle, La John C. Blaisdel	,						er's Name <i>(Fi</i> 1e Jone		Maiden Sum	ame)		
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_			30. Name and address of person we Kevin Knopf, M	D 900	Bestga	te Road) _ Aı	napo	lis, M	arylar	nd 21	401		
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DHMH 17 Rev 1/2001

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	Dhusis		Decedent's Name (First, Middle, Last)							2. Date of Dea		Vear	3. Time of Death
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			3006 Gallery Pl. A			Wald			i i i a		Char		
	Funeral Director		5. Social Security Number 220-38-1556 6. Sex Usual Residence of Decedent	7. Age (In yrs. last to	Yrs.	If Under 1 Months	Days	If Under 24 Hours	Min.	July	9 , 1939	9. Birthpla Counti Mar	ace (State or Foreign Yland
	land ow		10a. State 10b. County	10c. City, To	wn or Lo	cation						10	d. Inside City Limits
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21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show Ita Madical Examirer must be natified at	ed to	15. Decedent's Education	or Dates:	a Decec	lent's Usual	Occupat	ion			16b. Kind of Bus	in ess/Indu	ietn/
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<u>ya</u>	Ment Ment arkec	10	Joseph B. Butler					Eli			rown		
, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked othar than "natural; or Itams 23a or 28a-f show any injury or other traumatic avent. It is Medical Examiner must be notified at ance.		19a. Informant's Name/Relationship (Type, Print Mamie Butler/Wife	3	9b. Mailin 006	g Address (Gall	Street ar ery	Pl.	or Rural Ap	Route Number	r, City or Town, S Waldo:	tate, Zip (rf,	MD 20602
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Baltimore,	permit Depart Import any in		21. Signature of Funeral Service Licensee	19	22	. Name and 2065	Address Aq	of Facility uasc	ADA o Ro	AMS Fu d. Aqu	neral I	Home MD 2	6608
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ds,	ires ti signe	l by	Part II. Other significant conditions continuously	to dealif but not resulting	i iii tale ui	idenying cat	use givei	IIII FARI.		1 Y		ba	
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3ec	sician: The law certificate has b irector, page 2 s	mp							_	24a. Was a autops perfor	sy pri med? de	or to com ath?	sy findings available pletion of cause of
_	n: Th ficate rr, pay		as W							1 Yes	2 □ 460 1□		P No
Vital	Physician: rthis certificatal director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	1 ☐ Inpatient 2 ☐ ER/0	Outnation	t 3□ DOA	Other			(Check only or	ence 6 Other	(C===(6.)	
of	g Phy er this eral d	n: To			. Time of		c. Injury a Work?				ow injury occurred		
ion	Attanding death. ctor: Afte y the fun	atio	1 atural 5 Pending 2 Accident investigation	Month, Day Year)	Injury	м		es 2 🗆 No	0				
Division	Atta er deg racto by th	tifica	3 Suicide 6 Could not be determined 28e. I	Place of Injury - At home, ouilding, etc. (Specify)	farm, stre	et, factory,	office		2	Bf. Location (Si City or Town	reet and Number	or Rurai	Route Number,
Ō	Ital or A	Certification:								- ,	//		7
	To the Hospital or Attending Physician: The Within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	(Check only 2 Medical Examiner: On	o the best of my knowled the basis of examination a manner stated.	ge, death and/or inv	occurred at restigation, it	t the time n my opi	, date and nion, death	place, ar occurre	nd due to the c d at the time, d	ause(s) and man ate and place, an	ner as sta d due to t	ted. the cause(s)
	To the within To the Comp	ž	29b. Signature and title of certifier	1 AA		29c.	License	number		2	9d. Date signed	Month, D.	ay, Year)
			I knise	4 Mall		_ \	77	35)		4/6/	06)
			30. Name and address of person who completed	cause of death (Item 23a) (Type,	Print)- 1	Kr:	shar	Ma Ma	thur,	MDIOI	art. rest	
[1]	7 3		Date filed (Marth Co. V.	1705	(5/10	cje			9.0	7676)	
	Sta Registi		31. Date filed (Month, Day, Year) APR 1 0 2006	32. Alegistrar's Signature		2020							

Registrar

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

1 1 2006

	1 For State Registrar	State of Maryla		artment of I <i>rtificate of</i>		and Mental Hy	ygiene Reg. No.	6 12875
Physician /Medical	Decedent's Name (First, Middle, La	Max	В1	RICKMAN		2. Date of D April		Year 3. Time of Death 9:05 P M
Examiner	4a. Facility Name (If not institution, given Stella Maris Hos	spice		4b. City, Town, Timon i	um		4c. County of Balti	more
Funeral Director		Sex 7. Age (In yn 1 ₩ 2 □ F 81	s. last birthday, Yrs.	If Under 1 Year Months Days		Min. 8. Date of B (Month, D NOV •	22, 1924	9. Birthplace (State or Foreign
with the Maryland a or 28a-f ehow be rediffed at	10a. State 10b. County Maryland Baltir		Dity, Town or Li	Ltimore				10d. Inside City Limits 1 ☐ Yes 2 📉 No
th with the 23a or 2 ust be no	8711 Windsor Mil	L Road		10f. Zip Code 21	244		10g. Citizen of W United S	
nd 2 should be filled within 72 hours after death with the Maryland th and Mantal Hyglene. 27 is marked other than "naturel", or itame 23e or 28e-f show traumatic event, the Medical Exercities must be rictified. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ₩ Yes 2 □ No WW Year or Dates:	III	1 □ Yes 2 □ No	Specify:	gin? (Specify Yes <i>or</i> N , Puerto Rican, etc.)	Specify:	WILLE
ed within 72 houygiene. Yellen "nature t, the Medical E Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 1 2		Art:	dent's Usual Occu kind of work done DO NOT use retire	pation during most	of working	16b. Kind of Bus	siness/Industry
Mental Hy Briked other atic event,	17. Father's Name (First, Middle, Last Isidore Brid					r's Name (First, Middle ose Kopnic		9)
	19a. Informant's Name/Relationship Joan Perkiel, Nic 20a. Method of Disposition	20b.	3333		dson 1	or or Rural Route Number Parkway, B: Date	ronx, NY	State, Zip Code) 10463 City or Town, State
Permit. Pages 1 ar Depertment of Hea mportant: If item iny injury of other ones.	1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Services Lices)	(y) Mt	. Lebar	non Cemet	ery	04/11/06 ew Funeral	Adelphi	, MD
Physician /Medical Examiner	23a. Part. Firer the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it any leading to immediate	a. PROSTATE C Due to (or as a conse	ANCER equence of):	er the more of dy	1 St. ng, such as	NW Wash	inston, P	C 20012 Approximate Interval Between Onset and Death
eath certificate be executed attending physicien and for use as the burial-transit clary. Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse	equence of):					
0 0 0	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	ital death 3	Ectopic pregnand Other (specify)	у		23d. Date Mon	of delivery th Day Year
es tha igned be det	Part II. Other significant conditions	contributing to death but not re	esulting in the u	nderlying cause gr	ven in Part I.			bute to the cause of death? 3 Probably 4XJUnknown
The la ate has page 2							opsy pr form <u>e</u> d? de	dere autopsy findings available for to completion of cause of eath? Yes 2 \(\) No
Physician: The this certificate al director, pag.: To Be Cor.;	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	Hospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3□ DOA Ct	200	of Death Check only rsing Home 5 ☐ Res	40	r (Specify) HOSPICE
fter ine	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not to determine determined.	28e. Place of Injury - At	28b. Time o Injury	M 1	ryat rk?]Yes 2 □ t	No 28f. Location	(Street and Numbe	r or Rural Route Number,
To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the tr. Medical Certificati	29a. Certifier Certifying Pl	building, etc. (Spec nysician: To the best of my k miner: On the basis of examin	nowledge, deat	h occurred at the ti	me, date and	d place, and due to the	own, State) e cause(s) and man	ner as stated.
To the H vithin 24	29b. Signature and fittle of certifier	and manner stated.	Section of the section	29c. Licen		Journal at the till	29d. Date signed	(Month, Day, Year)
107	30. Name and address of person who		TWY TIAT T	TITE DD	THOM:	UM, MD 210		,0,00
State Registrar	31. Date filed (Month, Day, Year) APR 1 1	32 degistrar's Sign	EY VALI	esti	TITION	on, ru zit	,,,,	

APRIL 9, 2006 9:05 p.m.

MAX BRICKMAN

State of Maryland / Department of Health and Mental Hygiene | | | | Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** RODERICK BRINKLEY April 8, 2006 8:05A /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rockville Montgomery Shady Grove Adventist Hosp If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 13X M 2 □ F 50 Oct.10,1955 Brooklyn,NY Director 064-48-8067 Usual Residence of Deceden 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r then "neturel", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director MD Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25004 Angela Court 20872 U.S.A filed within 72 hours after death Funera 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 □ No 1978 —
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ Xo Specify: Š 3 Widowed 4 Divorced 1980 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 355 Toyota Parts Salesman permit. Pages 1 end 2 should be filed w Department of Health and Mental Hygies Importent: if Item 27 is marked other ti any injury or other traumatic event, Im-once. other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Joseph Brinkley Agnes Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ava Brinkley- Wife 25004 Angela Ct Damascus, MD 20872 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 4/15/06 Alexandria, VA Metro Fnrl Svcs 22. Name and Address of Facility 21. Signature of Funeral Service License Snowden Funeral Home, PA 246 N. Washington St Rockville ,MD20850 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Driset and Death Do not enter the mode of dying, such as cardiac or Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death signed by the all 5 Other (specify) 1 ☐ Yes 2 ☐ No o. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 Yes 2 No 3 Probably 4 Hinknown peeu 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform certificate 2 No 1 Yes 2 No 1 Yes of Vital Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Inpatient 2 ER/Outpatient 5 1 Yes 3 DOA this After this funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: Injury Division or Attending 5 Pending 1 TYes 2 No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after of To the Funeral Direct 4 Homicide 29a. Certifier 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Jem 23a) (Type, Print) MD 9900 Medical Center Dr Rockville, MD 20850 William R. Dooley,

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

1 1 2006

32 Registrar's Signature

Sq.		Stata Ragistrar			artment of Health and rtificate of Death		Reg. No. 006	3. Time of Deat
ysicia /ledica	n al	1. Decedent's Name (First, Middle, Las Julie L. Bryan			4b Ch Tuesday 4 Day	Month April	Day Year 9 2006 4c. County of Dea	1:17 A
amine eral ctor		4a. Facility Name (If not institution, give Washington Advent 5. Social Security Number 577-60-2152 Usual Residence of Decedent	ist Hospita	1 yrs. last birthday) Yrs.	4b. City, Town, or Location of De Takoma Park If Under 1 Year If Under 24 H Months Days Hours Mi	Irs. 8. Date of Birt	Montgome	
fled at		10a. State 10b. County MD Prince (City, Town or Lo				10d. Inside City Lin
at be not	al Direc	10e. Street and Number 7433 Baltimore Av	<i>7</i> e		10f. Zip Code 20912		10g. Citizen of What C United St	
any injury or other treumatic event, the Madical Examiner count be notified at once.	by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes No If Yes, Give Year or Dates:	in U.S. 13.	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Wh Specify: Wh	ite, etc.
Madical	npieted	15. Decedent's Ed (Specify only highest grade Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	1	dent's Usual Occupation a kind of work done during most of v DO NOT use retired)	working	16b. Kind of Business Federal Go	,
event, Its	Be Cor	17. Father's Name (First, Middle, Last)		Ana1	18. Mother's N	Name (First, Middle,	Maiden Surname)	A CT INTERIO
reumatic	ပ္	Urbino Lopez Ace	ype, Print)		Jobita ng Address (Street and Number or Baltimore Ave, 7		er, City or Town, State,	
or other t		Kathleen J. Bryan 20a. Method of Disposition 1 Burial 2 Cremation 3 D	Removal from State	b. Place of Dispersion	osition (Name of matory or other place)	Date 11-06	20c. Location - City o	r Town, State
any njury		4 □ Donation 5 □ Other (Specify 21. Signature of Juneral Service Licen		2:	2. Name and Address of Facility Jo	the state of the s		
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for use as the bur	cai	that initiated events	b. Due to (o) a a con	sequence of): egnancy Fetal death 3[□Ectopic pregnancy □ Other (specify)	·	23d. Date of de Month	alivery
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DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Ma	ırylar		artmen rtificat				lental Hy	/giene	000	12878
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35.	Funeral Director		5. Social Security Number 6. Se 040-18-1585 Usual Residence of Decedent	X 7. Age	o (in yrs.	9 Yrs.	If Under Months	Days	Hours	Min.	8. Date of B (Month, D Sept 9	rith lay, Year) , 19	9. Birth Cou Mass	place (State or Foreign intry) achusetts
	72 hours after death with the Maryland natural; or Iteme 23a or 28a-f ehow itsal Examinar must be notified at	Director	10a. State 10b. County Maryland Montgome 10e. Street and Number	ry		ty. Town or Lo						10a Cit	izen of What Cou	10d. Inside City Limits 1 Yes X No
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121	within 72 ho ene. than "netur ite Mudical	Completed	15. Decedent's Edd (Specify only highest grad Elementary/Secondary (0-12)		+)	16a. Deced (Give life.	kind of woi DO NOT us	rk done d se retired,	<i>furing</i> mos)	st of worki	ing		ind of Business/II	
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ylar	2 should be and Mental is marked o	To B	Walter Earle Thomp	son					Emily	7 Тор	ham			
ž	1 and 2 shoul Health and Milem 27 is mark		19a. Informant's Name/Relationship (T) Susan B. Dunton/da			1910	l Rho	des l	Way M	lont g	omery	Villa	age, MD	20886
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		20a. Method of Disposition 1 Burial 2 Commation 3 4 Donation 5 Other (Specify,			Place of Dispo cemetery, cren esapeal				_	1 ^{te} 12,		cation - City or T tsville,	
Ball	Departi Depart Import any in		21. Signature of Funeral Service Licens	Folth	MO1:	251 Be	ever1	v L.	Heck	rott	e. P.A	. C1a	P.O. Bo	x 784 e, MD 21029
	Physician /Medical Examiner	L	Sequentially list conditions.	a. End Stage Due to (or as a	e Rei	nal Dis		e of dying	g, such as	cardiac c	or respiratory a	arrest,		Approximate Interval Between Onset and Death
8760,	ate be executed hysician and the burial-transit	ical Examiner	ary, each go thin ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or as a d.										
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Division of	ding Ph After th funeral	ation: To	27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day		ER/Outpatien 28b. Time of Injury		8c. Injury Work	4 🗀 190	- 2	ne 5 ∐ Hes 28d. Describe			WHospice
S	tal or Attences after death	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injurbuilding, etc.	ry - At ho (Specify	ome, farm, stre	eet, factory	, office		1	28f. Location (City or To	Street an wn, State	d Number or Run	al Route Number,
	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edicai	one) 2 Medical Exami	ner: On the best of and manner stat	examina	wladge daath tion and/or inv	restigation,	in my op	e, date an inion, dea	d place, t	and due to the	causa(s) date and	and manner as a place, and due t	nated. o the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	~ m	10		29c.	. License					le signed <i>(Month,</i>	
02	-		30. Name and address of Person who of Joseph Kaplan M.D.	ompleted cause of de 6001 Mur				Ro	ckwi1	16	MD 208	55		
	Sta Registra	-	31. Date filed (Month, Day, Year) APR 12 2	32. Refistra	r's Signa				CKVII	.10,	ZUO.			

DHMH 17 Rev 1/2001

			1 - For State Registrar	_	aryland / Dep <i>Ce</i>		t of H	ealth a	and M			2006	12879	
1	Physic	ian	1. Decedent's Name (First, Middle, Las.	t)						2. Date of De		Day Year	3. Time of Death	_
	/Med	ical	Alice Banghart							April		2006	7:00P N	Λ
	Exami	ner	4a. Facility Name (If not institution, give					Location of	of Death		- 1 .	tc. County of Death	1	
	Funeral		AAT Home Family P 5. Social Security Number 6. Se		e (In yrs. last birthday)	Colu		If Under:	24 Hrs.	8 Date of Ri		Howard		_
	Director		Usual Residence of Decedent	□M 2 X)F	108 Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, Da Feb. 2	ау, <i>Үө</i> а 8,	1898 I11	nplace (State or Foreig untry) LNOIS	n
	death with the Maryland ms 23a or 28a-f show Linest be natified at	_	10a. State 10b. County		10c. City, Town or Lo	cation							10d. Inside City Limits	
	Ba-ts	Scto	Maryland Howard		Columbia								1 □ Yes 2 🛣 No)
	with t	Ē	10e. Street and Number			10f. Zip						Citizen of What Cou	intry?	
	leath	eral	5450 Phelps Luck D		Ever in U.S. 12.1	210					US			
36	after or Ita	by Funeral Director	1 Never Married 2 Married 3 Wildowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 22 If If Yes, Give Year or Dates:	No 113.	was Deced f Yes, spec 1 ☐ Yes 2		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)) -	14. Race - Amer Black, White	, etc.	
21215-0036	2 hou atura	ted	15. Decedent's Edu	cation	16a. Deced	dent's Usua	I Occupa	tion			16h	wnı		
215	thin 7: 9. 9n "n	Completed	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5	(Give	kind of wor DO NOT us	k done di e retired)	uring most	of worki	ing	100.	Kind of Business/li	ndustry	
	ed wit ygjene er tha	Com		4	Homema	aker					Owi	n Home		
ınd	be filk ital Hy id oth	Be	17. Father's Name (First, Middle, Last)	_	•			18. Mother	r's Name	(First, Middle	, Maide	on Sumame)		
Maryland	2 should be filed within 72 hours is and Mental Hygiene. Is markad other than "natural", aumatic avant. It a Medical Eva	²	(unk)		itswartz								(unk)	
Ma	d 2 st th and th sis in traun		19a. Informant's Name/Relationship (Ty	, . ,								or Town, State, Zi	o Code)	
	tam 27		Leslie Banghart/som	n	20h Place of Dione	cition /Alam	4					21045 Location - City or T	ave Ct-t-	_
ПO	Pages nent of int: If its		1 ☐ Burial 2 【XCremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	cemetery, cren	natory or oti	her place		Aprī 20	1º 10,				
Baltimore,	permit. F Departme Importar any injur		21. Signature of Funeral Service Licens	ee/ /) /.				-					Maryland	
ä	Depar Impor any ir		1 Deven & to	6 Cotto	MO1251 Be	oing F	lome	Crem	atio	n Servi	ice	P.O. Bo	x 784	
	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	_Myocard		er the mode	of dying,	, such as o	cardiac or	r respiratory ar	rrest,		Approximate Interval Between Onset and Death minutes	9
П	Examiner		Commence of the second		2 0000400100 01).									
ш	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury		a consequence of):									_
	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last											
8760,	be exclan clan courial.		resulting in death) case	Due to (or as a	a consequence of):									
687	physi physi s the t	dicai		l										_
P.O. Box (The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth of 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pre Other (spe	gnancy cify)					23d. Date of delive Month	ery Day Year	
	s that ned b e deta	by Pr	Part II. Other significant conditions con	tributing to death bu	it not resulting in the un	derlying cau	use given	in Part I.		23e. Did to	bacco	use contribute to th	ne cause of death?	
ords	w requires been signi should be	eted b									es 2	_	ably 4 \(\sum \text{Unknown} \)	
Vital Records,		e Completed	26 Was sees stand to said							24a. Was a autop perfor	sy med?	prior to cor death?	psy findings available impletion of cause of	
		To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 📉 No	ospital: 1 ☐ Inpatier	nt 2 ER/Outpatient	2000	Other			(Chack only or		12	ssisted	
Division of	ing After		27. Manner of Death 1 XNatural 5 Pending	28a. Date of Injury (Month, Day	28b. Time of		c. Injury a Work?	4 Nurs		e 5 L Resid		6 MOther (Specia	iving	
isic	tan leat tor: the	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	00-01		М		s 2 No						
Di∨	il or Attand after death Diractor: / d in by the f	Certification;	4 ☐ Homicide determined	building, etc.	ry - At home, farm, stre (Specify)	et, factory,	office		28	Bf. Location (S. City or Town	treet ar n, State	nd Number or Rura 9)	l Route Number,	
	a Hospital 24 hours a a Funaral C etely filled		29a. Certifier 1 X Certifying Phys	ician: To the best of	my knowledge, death	occurred at	the time.	date and	place, an	nd due to the c	ause/s) and manner as et	ated	-
	To tha Hospital or At within 24 hours after or To tha Funaral Dirac completely filled in by	Medical	one)	er: On the basis of and manner stat	examination and/or inve	estigation, in	n my opin	ion, death	occurred	d at the time, d	ate and	place, and due to	the cause(s)	
\	To To	~	29b. Signature and title of certifier	11/11/	11 ma		icense n	umber 34	7	2		te signed (Month, I		
			30. Name and address of person who cor	noleted source of	Oth (Itam 22=) ==	را دا	-10	.) T ,			1-+1	pril 8,	2006	
1)0			C. AVERILL	M Lause of de	LIS ROS	ES S	R	RI	61	EN R.	6 (1)	s MA 2	10100	
**	Sta Registr		31. Date filed (Month, Day, Year) APR 1 2 2006	32 Registrar	ath (Item 23a) (Type, P	ر بور		14	<u></u>	الل سا	101	C, 1.115 0		-
	3	. 5	7,1,7, = 7, 1,000	1 -4	100									

06-02393	3
Brunner,	Charles

Please Type or Print in Black Indelible Ink

runner, Charles	1- For State Registrar	tate of Maryla		artment o ertificate o		Mental H		Reg. No. 20	06	288
Physician/ /ledical Examiner	1. Decedent's Name (First, Midd	lle,Last) :les Brunn	er				2. Date of Dea Month April 7, 20	Day Year	3. Time o	
<i>Y</i>	4a Facility Name (if not institution 5616 April Journey				4b. City, Town, or Lo	ocation of Death		4c. County of Howard		
Funeral	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year			rth (MM/DD/YYYY)		tate or Foreigi
Director	074 42 8561	1 XM 2 F	56	Yrs	Months Days	Hours Min	05/09	7/1949	New Yo	ork
aus	Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Locat	ion				10d Insid	de City Limits
A	MD Howa	rd		lumbia	1011					es 2 × No
the Maryland a or 28a-f sh tified at one	10e. Street and Number	L C	CO	Taribla	10f. Zip Code		1	Og. Citizen of Wha	t Country?	
the M ka or 2 stiffed	5616 April Jou	ırnev			21044			United	States	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show in other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 M	12. Was Dec larried Armed F 1 Yes	2 X No		is Decedent of Hispa es, specify Cuban, f	anic Origin? (Sp			American Indian etc.	ı, Black,
hours after "natural", Examiner ted by F		or Dates:		1	Yes 2 X No			Specify:	White	
5-0036 Teled within 72 hour Tiled within 72 hour Hygene, d other than "natur, the Medical Exan	15. Decedent's Education (Spe Elementary/Secondary (0-12)	College (during most of	it's Usual Occupatio working life. DO NO intendant	T use retired)	vork done	16b. Kind of Busi		
5-0036 led within 7 Hygiene. Lother than the Medica	17. Father's Name (First, Middle,			Jagar	_		(First, Middle, I	Maiden Surname)	accion	
21215 uld be file Mental H marked o c event, tl	Al Brunner					auline (,		
ID 21215-003 should be filed within and Mental Hygiene. T is marked other the natic event, the Med To Be Com	19a. Informant's Name/Relations				Address (Street					·)
Baltimore, MD 2121 permit. Pages 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event, To Be	Sherry Brunner 20a, Method of Disposition 1 Burial 2 X Cremation				April Jou ition (Name of ceme ner place)		lumbia,	MD 21044 20c. Location - C		te
Baltimore, osemit. Pages I ar Department of Her Important: If ite Imjury or other tr	4 Donation 5 Other S	pecify:		etro Cr				Catons		
Balti permit. Departm Imports injury o	21. Signature of Funeral Service	Licensee	M01	044 22. 1	lame and Address o	f Facili Harr	y H. Wi	tzke's Fa	mily FH	Inc.
Physician /Medical Examiner	23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	on each line. a. Intraoral Gi Due to (or as a b. Due to (or as a c.	unshot Wou a consequence of a consequence of	i. Do not enter the nd off):	ne mode of dying, su	uch as cardiac or	respiratory arre	est, shock, or heart	Approxii Betwee	mate Interval in Onset and Death
ed nsit	events resulting in death) Last		consequence o	of):						
executed an and al - transit	UNPENDED	d. AMENDED								
lox 68 eath certi eath certi e attendin for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes,	nant at time of de	2 Fe	tal death 3 her (Specify)	Ectopic pregna	ncy	23d. Date of de Month	elivery Day	Year
i, P.O. E	Part II. Other significant condit	ions contributing to	o death but not r	esulting in the u	inderlying cause give	en in Part I.	23e. Did to	obacco use contribu		of death? Unknown
Division of Vital Records, tal or Attending Physician: The law require is after death. al Director: After this certificate has been significate by the functal director, page 2 should be briffication: To Be Completed							24a. Was a autop: perfor	sy prio med? dea	re autopsy findin or to completion of hth? Yes 2	
tal Reician: The certificate rector, page	25. Was case referred to medical				26.Place of	f Death (Check o				
n of Vit ding Physic h. After this of funeral dire	examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Page	28a. Date	of Injury Day, Year)	ER/Outpatient	njury 28c. Injury	at Work?		Residence 6 now injury occurred	Other Scene	
Division of spital or Attending I nours after death. The spital or Attending I present: After filled in by the function. Certification:	2 Accident Invest 3 Suicide 6 Coul	stigation Apr 7, 2 28e. Place	006 e of Injury - At ho		t, factory, office buil	ding, etc.	28f. Location (S or Town, Si	Street and Number (lumber, City
Di To the Hospital within 24 hours a To the Funeral I completely filled	29a Certifier (Check only 1 Certifying Pt	hysician: To the bes		ge, death occur		and place, and	due to the caus		started	
To with To com	29b. Signature and title of certifie	and manner s			29c. License r			29d. Date signed		ear)
	(hy al	HPQ 01	Odl		O.C.M.			April 8, 2006		
5)02	30. Name and address of person Carol Allan, MD Ass	who completed caus			Street, Baltimore	e, MD 21201				
State	31. Date filed (Month, Day, Year)	32. Re	atrar's Signatu							

DHMH 17 Rev 1/2001 OCME 10/2003 Baltimore, MD 21215-0036

Physician /Medical xaminer

	State	Please Type or of Maryland / Depa						giene				
	1- For State Registrar		tificate o				,	9	Reg. No	20	006	1288
/ er	1. Decedent's Name (First, Middle,Las Errol E. Brow	_					2	Date of D Month April 11	Day	Year		ime of Death 0230 hrs
	4a Facility Name (if not institution, given Howard County General H			4b. City, Towi Columbi		cation of I	Death			c. County o Howard	f Death	
_	5. Social Security Number $214-84-6319$ 4X	ex 7. Age (In yrs. la	ast birthday) 44 _{Yrs}	If Under 1 Months		If Under 2 Hours	24Hrs. Min.	8. Date of Jan		/DD/YYYY 962	Country	ce (State or Foreign
1	Usual Residence of Decedent 10a State 10b County Maryland Anne A	rundel G1	Town or Local									Inside City Limits Yes 2 X No
חופרוכ	10a State 10b. County faryland Anne A 10e Street and Number 8225 Great Ben 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 XDIvorce. 15. Decedent's Education (Specify of Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle, Last Errol E. Brown	d Rd.		10f. Zip Co	de 210	61			10g. Cit	izen of Wh	at Country?	
ובום	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 X No		as Decedent o Yes, specify C					No-	14. Race White		Indian, Black,
. vy	3 Widowed 4 XDivorce 15. Decedent's Education (Specify of	d If Yes, Give Year or Dates only highest grade completed)	16a. Deceder	Yes 2X nt's Usual Occ			nd of wo	ork done	16b.	Specify: Kind of Bu	B1ac siness/Indus	
וואובים	Elementary/Secondary (0-12) 12th	College (1-4 or 5+) 2yrs	_ most of	working life. I k Dri	<i>r</i> er							ibution
_						Mary	Ε.	First, Middl	lia	ms		0. 11)
0	19a. Informant's Name/Relationship (Errol E. Brown 20a. Method of Disposition	SR.(Father)	1019		lne	St.			tt	City		21043
	1 X Burial 2 Cremation 3 4 Donation 5 Other Specif.	Me	Place of Dispo crematory of d MOTIA	erast 1 Gard	len	s 4	-18	3-06			olis,	
Examiner	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause	plications that caused the death each line. a. Rectosigmoid period. Due to (or as a consequence of the con	i. Do not enter foration of): of):	the mode of d	ying, su	ich as car	diac or	respiratory	arrest, sh	ock, or hea	art A	pproximate Interval Jetween Onset and Death
cal Ex		d.										
Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow	AMENDED 23c. If yes, outcome of preg 1 Live birth 4 Pregnant at time of d	2 F	etal death Other <i>(</i> S <i>pecif</i> y	3 [Ectopic p	oregnar	псу	23	3d. Date of Month	delivery Day	Year
	Part II. Other significant conditions		resulting in the	underlying ca	iuse giv	en in Part	t I.	23e D	id tobacco	No 3		cause of death?
Completed by									utopsy erform <u>ed?</u>	, c		sy findings available bletion of cause of 2 No
Φ	25. Was case referred to medical			26.		of Death (0	Check o	inly one)				
tion: 10 B	27. Manner of Death Natural 5 Pending	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day, Year) April 11, 2006	ER/Outpatier 28b. Time of 2:30 AM		. Injury	at Work?	No	g Home 5 28d Descr. Found 1 proced	ibe how ir hours	dence 6 jury occurr after	other: red Pneur colono:	noperitoneu scopic
Certification:	2 X Accident Investigat 3 Suicide 6 Could not determine	28e Place of Injury - At h	nome, farm, str	eet, factory, o	fice bu	ilding, etc.		28f. Locatio	on (Street m, State)	Howard	Count	Route Number, City y General
Medical	29a Certifier 1 Certifying Physicone) 2 Medical Examin	ician: To the best of my knowled er: On the basis of examination and manner stated.							date and p	lace, and o	due to the ca	
š	29b. Signature and title of certifier			29c L	icense	number			29d	Date sign	ed (Month,	Day, Year)

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, After this certificate has been within 24 hours after death

To the Funeral Director: After this certifi
completely filled in by the funeral director,

> 30 Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Ana Rubio MD. 31 Date filed (Month, Day, Year) APR 1 9 2006

32. Registrar's Signature

MD

ORIGINAL

O.C.M.E

111 Penn Street, Baltimore, MD 21201

April 12, 2006

Registrar DHMH 17 Rev 1/2001

OCME 10/2003

State

			_ For	State of Maryland	d / Depa	artment of H	ealth and	•		10000
			1 - State Registrar		Cei	rtificate of L	Death	Re	g No J U O	12002
	Physicia		1. Decedent's Name (First, Middle, Las Lucile	Green Collir	ıs			2. Date of Death Month April 5	Day Year 2006	3. Time of Death 4:30am
	/Medic Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or	Location of Deat	h	4c. County of Deat	h
	LAUITIII	-	Sacred Heart Nurs	sing Home		Hyattsv	ille		Prince G	eorge
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day,		hplace (State or Foreign
	Director		241-40-5013	^{□ M 2} 🖾 F 76	Yrs.	Mortins Days	Hours Will.	Jan. 29,	1930 Nort	h Carolina
	D.		Usual Residence of Decedent							
	how	L	10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits
	e Ma	cto	Maryland Prince (George Hya	ittsvi	11e				1⊠Yes 2□No
	or 28	Directo	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	-
	filed within 72 hours after death with the Maryland Hygiene. ther then "neturel", or Items 23a or 28e-f show ant, the Madical Evandraer must be rediffed at	al	5805 Queens Char	oel Koad		20782			United St	ates
	ems erm	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (S n, Mexican, Puer	specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White	
ထ္ထ	afte or It	F	1 Never Married 2 Married	1 ☐ Yes 2X No If Yes, Give	1		Specify:		Specify: B1	ack
21215-0036	ours irel',	d by	3 🗷 Widowed 4 🗆 Divorced	Year or Dates:						
Ϋ́	72 h	Completed	15. Decedent's Ed (Specify only highest gra		16a. Dece	dent's Usual Occupa kind of work done of DO NOT use retired	ation <i>Juring</i> most of wo	rking	6b. Kind of Business/	Industry
2	vithin ne. hen	ш	Elementary/Secondary (0-12)	College (1-4or 5+)					-	
2	lled v tygie her t	ပိ	GED 17. Father's Name (First, Middle, Last)		limek	eeper/Qua		ne (First, Middle, M		
E C	be frail H	Be	Richard G					garet Vau		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel; or Items 23a or 28e-f show any injury or other treumetic event, the Medical Exactiner must be rediffied at angle.	၉	19a. Informant's Name/Relationship (Time (Reject)	10h Maili	na Address (Street s	and Number or Pi	ural Pouto Alumbor	City or Town, State, 2	Zin Code)
<u>a</u>	l 2 sh n and reun	0 8	Darnella Newman/Da		A	Clocktow			•	LIP CODE)
Ġ,	1 and Health		20a. Method of Disposition			osition (Name of	or Ent,		Oc. Location - City or	Town State
0	ges If ite		1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	emetery, crei	matory or other place	1			
<u></u>	tmer tent tent		`4 □Donation 5 □ Other (Specif			Veteran c			lew Bern, l	NC
Baltimore,	Depar Depar Impor any in		21. Signature of Funeral Service Licer	ISOO AND		2. Name and Addres	is of Facility	Fope Fune	ral Homes boro Pike	
	20 = e a		(eva)	1 July	1			Forestvil	le, MD.	20747
Г			23a. Part1. Enter the disease or com shock, or heart failure. List only	one cause on each line.	1. Do not en	ter the mode of dying	g, such as cardia	c or respiratory arre	St,	Approximate Interval Between Onset and Death
,	Pnysician	S 1	Immediate Cause (Final disease or condition	a Atheroscler	osis					
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):					
0	Examiner		Sequentially list conditions.	b. Cardiomyopa						
	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):					
	te be executed ysiclan and e burial-transit	Examiner	that initiated events resulting in death) Last	c						
760,	e exe		resulting in death) Last	Due to (or as a consequ	uence of):					
376	ate b hysic	IIcal		_ d						
89	death certificate be attending physical for use as the b	Physiclan/Medi	IF FEMALE:							
Вох	th ce tendi	an/l	23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnancy			23d. Date of del Month	livery Day Year
	0 0 0	SC	in the past 12 months? 1 □ Yes 2 □ No	4☐ Pregnant at time of de 9☐ Unknown	eath 5[Other (specify)			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Duy . Ju.
P.O.	requires that the death een signed by the atter hould be detached for u	Phy	9 Unknown					on- Diller		the revenue of decade?
Ś	gned be de	by	Part II. Other significant conditions of		ulting in the c	inderlying cause give	en in Part I.		acco use contribute to	
DIG	w require been sig	led	Diabetes, Hyp	pertension				1 🗆 Ye	s 2 No 3 P	obably 4 XUnknown
S	aw S S	ompleted						24a. Was ar autopsy	prior to	utopsy findings available completion of cause of
æ	9 4 9	E O						perform	ed? death?	2 □ No
Vital Record	icien: Th certificate rector, pag	Be C	25. Was case referred to medical				26. Place of De	ath (Check only one)	
>		10	examiner? 1 ☐ Yes 2 🎛 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3 DOA Othe	er: 4 🛛 Nursing l	Home 5 Reside	nce 6 Other (Spe	cify)
J Of			27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Injun Worl	/ at </td <td>28d. Describe ho</td> <td>w injury occurred</td> <td></td>	28d. Describe ho	w injury occurred	
Division	Attending ir death. ector: After by the fune	atlo	1 X Natural 5 ☐ Pending 2 ☐ Accident investigatio	n		M 1 🗆 '	Yes 2 □ No			
<u>Vis</u>	or Attendated after death Director:	ii Si	3 ☐ Suicide 6 ☐ Could not b		ome, farm, st	reet, factory, office		28f. Location (Str. City or Town	eet and Number or Ru State)	ural Route Number,
	elor A s after el Dire	Certification;		o and major to the poor of	,					
	To the Hospital within 24 hours a To the Funeral I completely filled	al	29a. Certifier 1 Certifying Pt	nysician: To the best of my kno niner: On the basis of examina	wledge, deat	th occurred at the time	ne, date and plac	e, and due to the ca	use(s) and manner as	s stated.
	n 24 n 24 he Fu	ledical	one)	and manner stated.	tion and/or ir	ivestigation, in my of	Dinion, death occ	urred at the titre, da	te and place, and due	to the cause(s)
	To the Within 2 To the comple	Σ	29b. Signature and tipe of certifier	1		29c. License	e number		ld. Date signed (Mont	
	121		· Kawa	4 h ta	e.	119	609		April 5, 2	2006
	Coin		30. Name and address of person who							
	Sic		Raman R. Tuli, N			n rd; Sui	te 202 G	aithersbu	rg, Md. 2	20878
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ture					
	Regist	rar	APR 0 7 2006	were to the	The state of					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** April Day 2006 Florene Page Chisley 3, 2:30 pM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 500 N.Harry S.Truman Dr. #215 Largo Prince Georges 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 12/01/1948 Birthplace (State or Foreign Country)
 S . C . **Funeral** 1 □ M 💥 □ F 57 Director 579-64-1906 Usual Residence of Decedent the Maryland 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits 27 Ia marked other than "natural", or items 23a or 28a-f show traumatic event, I.e Modical Exa oli not i ust be rediffed at 1⊠Yes 2□No Director Prince Georges Largo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Truman Dr. #215 500 N. 20774 Harry S. U.S.A. death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) s 1 and 2 should be filed within if Health and Mental Hygiene. item 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Security Officer Private 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Cabbagestalk Odessa Page 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Corene Wilkins / Daughter 4110 Ames St. #101 Washington, DC 20019 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit, Pages 1 Department of H Important: If ite any injury or ot once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State VETERANS CEM. 04 - 11 - 06CHELTENHAM, MD. * 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Lieensee 22. Name and Ronal de Taylor, II Funeral Chapel 10583 Middleport Ln. White Plains, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Metastatic Carcinoma of the Breast /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine attending physician and for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) 4☐Pregnant at time of death Records, P.O. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Anasarca 4 🗹 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed Leucopenia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an performed? Yes 2 ☑ No 1 ☐ Yes Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 WNo ۵ this 28a. Date of Injury (Month, Day Year) After the funeral 27. Manner of Death 28b Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending within 24 hours after death, To the Funeral Director: Al 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ry Como Altendra A D42580 APRIL 5, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parmjit Singh Aujla - 5632 Annapolis Rd., Suite 13 Bladensburg, 32. Registrar's Signature Date filed (Month, Day, Year) State APR 0 7 2006 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ap 4911 3, 2006 **Physician** Ruth Marcus Colner Yeer 4:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth | September 24, | 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1918 NY **Funeral** 099-14-0386 1 □ M 2**X**□ F 87 Yrs. Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at MD 1 Yes 2 No Montgomery Silver Spring Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 10701 Cavalier Drive 20901 United States 238 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Itema (Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No ģ White 3 ☐ Widowed 4 ☐ Divorced "naturai". Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) s 1 and 2 should be filed within if Health and Mental Hygiene. Itam 27 is marked other than "r College (1-4or 5+) Elementary/Secondary (0-12) School Teacher Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Abraham Marcus Miriam Rosman 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code $10\,701\,$ Cavalier Drive Silver Spring MD $20901\,$ 19a. Informant's Name/Relationship (Type, Print) Bernard J. Colner - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If its
any injury or ot 1 Burial 2 Toremation 3 Removal from State
4 Donation 5 Other (Specify) National Crematory 4/11/06 Falls Church VA 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels Inc. 21. Signature of Funeral Service License Donald (1170 Rockville Pike Rockville MD 20852 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (or as a consequence of): neumonio Physician disease or condition resulting in death) /Medical Examiner no xia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine requires that the death certificate be executed anding physicien and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physicien Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 🗌 Yes 2 🛮 No To the Hospital or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☑*Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 K Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funarel Director: 2 Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of D0063256

State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7600 Caroll Ave.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** James Clifton Campbell 2006 5:00 A April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ft. Washington Hospital Ft. Washington Prince George's 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F Months Days Hours Yrs. Director 579-01-9602 101 Feb. 19, 1905 Maryland Usuel Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthen "naturel", or items 23s or 28e-f ehow the Medical Examinar must be notified at 1 X Yes 2 No Director Maryland | Prince George's Forestville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20747 3001 Tracy Lane United States by Funeral deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Maritaf Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify Black 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6th Stock Yard Worker Government other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked oth any ulay or other traumatic event onch. Be ပ James Grant Campbell Mary Velma Penny 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Winfield E. Taylor/Nephew 3004 Tracy Lane, Forestville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Lincoln Memorial Cem. 4/10/2006 Suitland, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shocl, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or andition resulting in death) Cirdinumulan Physician Alterasclenatic 34 /Medical Due to (or as a consequence of): Examiner Renal 2 60 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physicien a s the burial Box 68760 Physician/Medical ettending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part fl. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Division of Vital Records. 3 ☐ Probably 4 ☑Unknown 1 Yes 2 No Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificete hes tirector, page 2 s autopsy performed? 1 ☐ Yes 2 ₺\No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2₽No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Natural 2 Accident 5 Pending death. 1 Yes 2 No investigation Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in within 24 hours a

To the Funerel C

completely filled 29a, Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D45365 1170/ livingston Ad It 10/, fort watchington Mp 20744 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

michael SidaRous n.D.

APR 0 6 2006

31. Date filed (Month, Day, Year)

32 Registrar's Signature

			For State Registrar	_	State	of Maryl	and / De	oartmen e <i>rtificat</i>				ental Hy	giene Reg. No.	106	128	86
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	/Medic Examin		4a. Facility Name (If n		-					Location o		-		County of Deat		
			HOLY CR	-	OSPITA:	-	um lant historia		LVEI 1 Year	R SPI		8. Date of Bi		NTGOME	ERY hplace (State of	or Foreign
	Funeral Director		5. Social Security Num 336-20-3 Usual Residence of D	489	1□ M 2Ø F		yrs. last birthda Yrs.	Months	Days	Hours	Min.	MAR 1	ay, Year)	Co	NE	or r oranger
	aryland show	_	10a. State	10b. County MONTG	OMEDV	1	City, Town or		NC						10d. Inside C	ity Limits
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036	n 72 hours after death with the Maryland "naturel", or liems 23a or 28a-f ehow calcal Examinat must be notilised at	by Funeral	11. Marital Status 1 Never Married 3 Widowed 4	_	d 1 ☐ Ye	ecedent Ever Forces?, is 2 No Give r Dates:	in U.S.	3. Was Dece If Yes, spe 1 ☐ Yes	10	ispanic Ori n, Mexicar Specify:		ecify Yes or N Rican, etc.)		4. Race - Ame Black, Whit Specify: WH	e, etc.	
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Maryland	d be ental ked o	To Be Co	17. Father's Name (F HENRY P									(First, Middle JOHNS		Sumame)		
Mar	s 1 and 2 should f Health and Men Item 27 Is marke other traumatic		19a. Informant's Nam KEITH C											Town, State, 2 RSBURO		879
Baltimore,	m O _ L		20a. Method of Dispo	Cremation 3		- 01-1	ob. Place of Dis cemetery, c ARLING	rematory or o	ther plac	_{e)} rery) 2006		cation - City or INGTON		
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	nysician		Immediate Cause (F	failure. List o	nly one cause o	n each line.		enter the mod	te of dyin						Approximation Interval Bet Onset and 1 hr	te tween
	/Medical Examiner		disease or condition resulting in death)	1	Due		nsequence of):	THOKE							1 hr	
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3760,	ate be executed hysician and the burial-transit	Ical Examiner	that initiated events resulting in death) La		c Due	to (or as a cor	nsequence of):									
O. Box 6	The law requires that the death certificate ate has been signed by the attending phys page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent print the past 12 mm 1 Yes 2 7 9 Unknown	onths?	1 Liv 4 Pr	outcome of pr e birth 2 D egnant at time	Fetal death	3 □Ectopic p 5 □ Other (s)				W	2	3d. Date of del		Year
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Records,	faw requires been as 2 should	Completed	ATRIAL									24a. Wa auto	psy	prior to	utopsy findings completion of c	available cause of
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=	siciar s certif irecto	o Be	25. Was case referre examiner? 1 ☐ Yes 2 Z N		Hospital:	☐ Inpatient	2 R/Outpa	tient 3 D	Othe			me 5□ Bes		S □Other (Spe	cifu)	
Division of Vital	Hospital or Attending Physician: 24 hours after death. Fureral Director: After this certificities in the funeral director.	ation: To	27. Manner of Death 1 Natural 2 Accident	5 Pending	28a. Da (N	ate of Injury fonth, Day Yea	-	of	28c. Injun Worl			28d. Describe			<u>,,</u>	
Divis	tal or Attend s after death al Director: / ed in by the f	Certification;	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	289. FI	ace of Injury - pilding, etc. (S)	At home, farm, pecify)	street, factor	y, office				(Street and own, State)	d Number or R	ural Route Nun	nber,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one)	Certifying Medical E	Physician: To xaminer: On th and m	the best of my e basis of exa namer stated.	knowledge, de mination and/o	eath occurred investigation	at the tim	ne, date ar pinion, dea	nd place, ath occurr	and due to the red at the time	cause(s) , date and	and manner as place, and due	s stated. to the cause(s)
	To the within 2 To the complete	ž	29b. Signature and ti	tle of certifier			11.			e number				e signed (Mont		
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	3		30. Name and address	ss of person w GOLD ,			(Item 23a) (Ty) ADY GR		D.,	#201	l, R	OCKVII	LLE.	MD 20	850	
	Sta Regist		31. Date filed (Month			egistrar's										

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Andrew Corrinne Eugene APRIL 08,2006 06:40 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner CIVISTA MEDICAL CENTER LAPLATA
If Under 1 Year If Under 24 Hrs. CHARLES 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months Days Hours Min 1**∑** M 2□ F Yrs. Director 173-14-2402 86 1919 Pennsylvania Usual Residence of Decedent 10a State 10b Counts 10c. City. Town or Location 10d. Inside City Limits 28e-f show Execution rount be notified at 1 Yes XXNo Directo Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 3060 Chestnut Drive 20603 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married 0 Maryland 21215-0036 1 Yes 2 No Specify þ Specify: White 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12 Shop Foreman Ice Cream permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any july or other treumatic event 20x8. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anthony Francis Corrinne Vera Morena 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcella Olson Corrinne/Wife 3060 Chestnut Drive, Waldorf, Maryland, 20603 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 4-11-06 4 □ Donation 5 □ Other (Specify) Clinton, MD 21. Signature of Juneral Service Licensee M01391 22. Name and Address of Facility 3035 Old Washington Road the Heat Huntt Funeral Home POB 156, Waldorf, MD 20604 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each time. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician nemmon /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine -transit or Attending Physician: The taw requires that the death certificate be executed Due to (or as a consequence of) physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic oregna//cv in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 2**2** No 25. Was case referred to medical 26. Place of Death | Check only one examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2€No 1ÆInpatient 2 2 ER/Outpatient 3 DOA 28c. Injury al Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 ANatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a Hospital 29a. Certifier Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8/06 Jahr athr D-52289 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1813 NALIN MATHUR, MD 10 ST.PATRICKS DRIVE SUITE 404 WALDORF, MD. 20603 31. Date filed (Month, Day, Year) APR 1 1 2006 32. Regis ar's Signature State Registrar

Box 68760

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	Physicia /Medic		Decedent's Name (First, Middle, I MELODYE MICHELL		ROBINS	ON					2. Date of De Month APRIL	- 1	^{Day} 200 6	Year	3. Time of Death 3:35 A M
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	Funeral Director		230-80-3472	. Sex 1□M 2☐F	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Months	1 Year Days	If Under Hours	Min.	8. Date of Bi	23,	^{ar)} 1954		lace (State or Foreign INIA
	Maryland a-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County MD CHAR	LES		City, Town or Lo	ocation							1	0d. Inside City Limits
	3a or 28	I Direc	10e. Street and Number 2951 MARSH HAWK	DRIVE			10f. Zip (Code 20 6	603				Citizen of V		-
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Maryland	1 end 2 sho Health and ! em 27 le ma		19a. Informant's Name/Relationship WILLIAM ROBINSON		AND	1	-				ral Route Numb			State, Zip 2 0603	Code)
Baltimore,	ages 1 er ent of Hea nt: if Item ry or othe		20a. Method of Disposition 1 ☐ Burial 2 ★ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		Ctata	Place of Dispo cemetery, crei E HUNTT C	matory`or oti	her plac	(e)		Date 10, 2006		Location ALDOR		
Balti	permit. Pages 1 Department of H Important: if Ite any injury or ot		21. Signature of Funeral Service		NSON	sur =	HORNI 439 I.	ON E	UNER	ÄL H	OME, P.	A.	I HEAI	o. MD	20640
	Fnysician /Medical Examiner	iner	23a. Part1. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	aDue to	caused the de each line. G CANCE (or as a conse	R equence of):	ter the mode	of dyin	g, such as	s cardiac	or respiratory	arrest,			Approximate Interval Between Onset and Death
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Division	of or Attending effer death. I Director: Affe d in by the fune	Certification;	3 Suicide 6 Could no determine	ad 200. Flat	e of Injury - At ling, etc. (Spe	home, farm, st	reet, factory,	, office	. , , _ ,		28f. Location City or To	(Street own, St	t and Numi tate)	ber or Rura	al Route Number,
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	To th within To th compl	Me	29b. Signature and title of certifier	e H	M	an	29c.		e number 3352				Date signe /10/00		Day, Year)
•	1		30. Name and address of person wi	completed cau	se of death (It	em 23a) (Type,	Print)								

State Registrar

DHMH 17 Rev 1/2001

20646

P.O. BOX 1703, LA PLATA, MD

31. Date filed (Month, Day, Year)

APR 1 1 2006

APR 2 2006

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death April 9, Day 2006 **Physician** Regina Catherine Cowell 4:38 a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 17704 Tree Lawn Drive AS:...
If Under 1 Year
Days Montgomery If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) 5. Social Security Number **Funeral** 1□M **¥**□F Months 213-48-7184 94 Oct. 11, Maryland Director Usual Residence of Decedent death with the Maryland 10c City Town or Location 10d. Inside City Limits 10b. County 10a State r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 TYes 2 TNo Directo Maryland Montgomery Ashton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 17704 Tree Lawn Drive 20861 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after begarment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ites any injury of other traumatic event, It a Madical Example once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White δ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 8 Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Vernosia Kelly Frank P. Welsh 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 17704 Tree Lawn Drive, Ashton, MD 20861 Joan C. Hueter/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Aprilate 11. 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 2006 Gate of Heaven Cemetery Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Francis J. Collins Funeral Home Inc 500 University Blvd, W, Silver Spring, Md 20901 21. Signatury of Huneral Service Licensee ille Approximate Interval Between Onset and Death ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final Physician disease or condition resulting in death) Pneumonia 2 Weeks /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner physicien and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Completed by Physician/Medical as attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav ŏ in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No Division of Vital Records, P.O. the 9 Unknown 9 ☐ Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia 1 Yes 2 No 3 Probably 4 Unknown should should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy performed? certificate 28 No 1 ☐ Yes Attending Physicien: 25. Was case referred to medical 26. Place of Death | Check only one Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 XResidence 6 Other (Specify) ဥ 1 Tes 2 XNo this funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: After Injury id or At.

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of Director: Al.

in by the fur-1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aft 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D23124 April 10, 2006 Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis M. Hannon, M.D. 2901 Olney-Sam 2901 Olney-Sandy Spring Road, Olney, Maryland 20832 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Alle 2006 St. Wash Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2006 4c. County of Death 11:05a В. Currie April 9, /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville Alfred House If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Hours **Funeral** 1 □ M 2 □ F Arizona Oct. 25 1906 99 Director 092 30 2521 Usual Residence of Decedent 10d. Inside City Limits deeth with the Maryland 10c. City, Town or Location 10b. County ir than "naturel", or items 23s or 28e-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2X No Director Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12913 Buccaneer Road 20904 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White Baltimore, Maryland 21215-0036 þ 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) il Hygiene. Other than Public Schools Teacher permit. Pages 1 and 2 should be filed Deperment of Health and Mental Hyg Important: if Item 27 is marked other any injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Anna Schmid P Felts Baldwin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12913 Buccaneer Road Silver Spring, MD 20904 Douglas Currie / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State Sylvan Abbey Mem Park 4/ 18 /06 Clearwater, Florida 4 □ Donation 5 □ Other (Specify) 22. Name and Address of FacilitHines Rinaldi Funeral Home 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave Silver Spring, MD 20904 120 C 231. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Coronary Artery Disease disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): ettending physicien for use as the burial Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 DEctopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? funeral director, Be Other: 4 Nursing Home 5 Residence 6 XOther (Specify) 1 Ving Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No 2 Sic 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: 5 Pending To the Hospins. Within 24 hours effer death.
To the Funerel Director: Aff 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified April 10. 2006 D0055694 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alok Mathur, M.D. 4000 Olney-Laytonsville Road Olney, Maryland 20832 State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Max Crownover April 11:05 a 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner E1kton Ceci1 SunBridge Care and Rehab If Under 24 Hrs. If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X** M 2 □ F 76 Yrs. Director Aug. 19, 1929 413-40-9939 Tennessee Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show r than "natural", or Itema 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 ₩ No Maryland Cecil Port Deposit Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 22 Cedar Drive 21904 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 107.0 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Types 2 No 1949—
If Yes, Give
Year or Dates: 1952 72 hours after 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ No Specify. 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) should be filed within Ind Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Sheet Metal Worker Metal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be find and Mental H Marie Payne Richard Crownover 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 ment of Health a ant: If item 27 ls 118 Starboard Court, Perryville, Maryland 21903 Charles Crownover/son other t altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Sherwood, Tennessee April 13, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department c Important: If any injury or once. injury or Crownover Cemetery 4 ☐ Donation 5 ☐ Other (Spacify) 2006 21. Signatur Fin yai Service Licens 22. Name and Address of FacilityCrouch Funeral Home de. 127 South Main Street, North East, Maryland 21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit The taw requires that the death certificate be execu Due o (r as a consequence of): Box 68760. attending physician Completed by Physician/Medical the as use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day Year ō in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9□ Unknown Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pe 1 ☐ Yes 2 ☐ No 3 Probably 4-0 hknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 No or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Harsing Home 5 Residence 6 Other (Specify) ပို 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA this funeral 2%a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investiga on Director: A 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determ, 4 Thomicide after within 24 hours aft

To the Funeral Di

completely filled in Dentifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of APril 10,2006 rson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of 34 | VA JENGINE DE 1970 ORR) CIDRCHIMOUS

DHMH 17 Rev 1/200

State Registrar 31. Date filed (Month, Day,

2006

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registral QQ Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** 2006 Gurney Courtland Clarke Apr 8:35a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | Il Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Min. Days 1**2** M 2 □ F Months Hours Director 234-54-4904 70 May 29, Usual Residence of Decedent with the Maryland 10c City Town or Location 10d, Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural; or itams 23s or 28a-f show any Injury or other traumatic event, if a Medical Eventing must be notified at once. 10a State 10h County 1 ☐ Yes 2 ☑ No Anne Arundel Severna Park MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 367 Preswick Way 21146 USA by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: White Specify 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Utility Equipment Sales Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel Clarke Gladys Glotfelty ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 367 Preswick Way, Severna Park, MD Joan Clarke/Wife 20b. Place of Disposition (Name of cometery, crematory or other place)
Metro Crematory 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Apr 2006' Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Approximate Interval Between Onset and Death enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence off Examiner signed by the attending physician and doe detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Yes should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has e 2 2 100 1 ☐ Yes 2 ☐ No certificate 1 Yes or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 🗡 0 1 Inpatient 2 ER/Outpatient 3□ DOA 2 this After the 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the Director: 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) filled in by 4 \ Homicide within 24 hours after To the Funeral Dire 29a. Certifier 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and 29c. License number 200 30. Name and address of person w completed cause of death (Item 23a) (Type, 6 31. Date liled (Month, Day, Ye Registrar's Signature State Registrar

	į.	Please	Type or Print in State of Marylar	nd / Dep	artment of I	Health and	=	_	12893
		Registrar		Ce	rtificate of	Death	1	Reg. No.	16.000
Physici		1. Decedent's Name (First, Middle, La Patrick	A.		Chamber	s	2. Date of De	Day Yes	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, given	re street and number)		4b. City, Town, o	or Location of Deat		4c. County of D	eath
Funeral Director		Baltimore Washing 1 5. Social Security Number 232-62-9765	ton Medical Ce. Sex 7. Age (In yrs 120 M 20 F 66	nter . last birthday Yrs.	Glen Bu If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birt May 17,	Anne Ar 1939 Wes	Country) Birthplace (State or Foreign Country) St Virginia
2 :		Usual Residence of Decedent 10a. State 10b. County	100 C	ity, Town or L	ocation				10d. Inside City Limits
-f sho	tor	MD Anne Art		nnapo1					1 ☐ Yes 2 🙀 No
"natural", or items 23a or 28e-f show dical Examiner must be notified at	i Director	10e. Street and Number 1583 Secretariat	Drive		10f. Zip Code 214	09		10g. Citizen of What USA	Country?
BE THE	Funerai	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13	Was Decedent of I	Hispanic Origin? (S an, Mexican, Puer	pecify Yes or No to Rican, etc.)	- 14. Race - A Black, W	merican Indian, hite, etc.
acamir.	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1XXes 2 No lfXes, Give Year or Dates: 6.2 —	66	1 ☐ Yes 21 No	Specify:		Specify:	White
deal	eted	15. Decedent's E (Specify only highest gr	ducation	16a. Dec	edent's Usual Occup e kind of work done	during most of wo	rking	16b. Kind of Busine	ss/Industry
han Ne Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 04		DO NOT use retire ion Manag	*		Social Sec	curity Admin.
marked otner	To Be C	17. Father's Name (First, Middle, Last Charles	dward	Cham	bers	18. Mother's Nar Rache		Maiden Sumame) Arnett	
or other traumatic	⊢	19a. Informant's Name/Relationship Amy Chambers I	Туре, Print) Daughter					or, City or Town, State	· ·
ant: If item aury or other		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Speci	20b. Removal from State	Place of Disc	osition (Name of ematory or other pla	1	Date	20c. Location - City Baltimore,	or Town, State
Important: If i any injury or once.		21. Signature of Euneral Service Lice	all		22. Name and Addre Hardesty	ess of Facility Funeral I	Home P.A	. 851 Anna Gambrills,	MB ¹ iso RD
sician		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	one cause on each line.		nter the mode of dyi	ng, such as cardia	or respiratory ar	rest,	Approximate Interval Between Onset and Death
dical niner		disease or condition resulting in death)	Due to (or as a conse		-	cicewi			
	Jer.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or an a conne	quience of)	100				
transit	aminer	Cause (Disease or injury that initiated events resulting in death) Last	c						
physician ar s the burial-t	icai E		Due to (or as a conse	quence or):					
hed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3	□Ectopic pregnand □ Other (specify) _	у		23d. Date of Month	delivery Day Year
d be de	þ	Part II. Other significant conditions	contributing to death but not re	sulting in the	underlying cause gr	ven in Part I.		obacco use contribute	e to the cause of death? Probably 4 Munknown
page 2 shouk	Completed			-				an 24b. Were prior death 2000 1 0 Y	
certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	7.50	Ot	her	ath (Check only o		
er this eral di	n: To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time	SIL 3 DOA	4 Nursing F		dence 6 Other (S now injury occurred	pecify)
Director: After in by the funer	Certification:	1 Watural 5 Pending 2 Accident investigation 3 Suicide 6 Could not to determine	28e. Place of Injury - At I	injury	M 1	Yes 2 No	28f. Location (5	Street and Number or	Rural Route Number.
ojre in b		4 Hornicide	building, etc. (Spec	ify)			City or Tow	vn, State)	
To the Funeral completely filled	Medical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exe	hysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, dea ation and/or i	th occurred at the tinvestigation, in my	me, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and manner date and place, and c	as stated. fue to the cause(s)
within 24 Protection of the Fusion Completely	Me	29b. Signature and title of certifier	£ 11)	Du Ma	29c. Licen	se number		29d. Date signed (Mo	onth, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

29c. License number D 41365

29d. Date signed (Month, Day, Year)
March 31, 2024

			For State Registrar	State of Ma	arylan			nt of He te of D				giene Reg. No	1000	12	894
13		4	Decedent's Name (First, Middle, L.	ast)							2. Date of De	ath		3. Tin	ne of Death
	Physici /Medic		Doris Christine	Chrzanowsl	ci						04/03/	200 <i>6</i>	•	5:1	4 P M
	Examin	-	4a. Facility Name (If not institution, gr				4b. City	, Town, or	Location	of Death		40	. County of Dea	th	
		. 75	Anne Arundel Me					apoli					ne Arur		
	Funeral		Social Security Number 6.	Sex 7. Ag 1 ☐ M 2 🛣 F		last birthday)	If Unde Months	er 1 Year Days	If Under Hours	Min	8. Date of Bir (Month, De May 22	th ly, Year)	9. Bir	thplace (Standary)	ate or Foreign
347	Director		220-44-0023		93	Yrs.					May 22	, 15	112 Wash	ingto	n, DC
	land w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Insid	le City Limits
	Marylan febow	ŏ	Maryland Anne Ar	undel	Ann	apolis								13(2)	Yes 2 □ No
	28a	Director	10e. Street and Number	<u> </u>				ip Code				10g. Cit	tizen of What Co	ountry?	
	3a o	<u>=</u>	2700 South Haven	Road			21	401				USA			
	within 72 hours after death with the Maryland ane. then "natural", or items 23s or 28s-1 ehow ha Mudicel Ezar in er musi Le codified at	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13.	Was Dec	edent of His	spanic Or	rigin? (Spe	city Yes or No)-	14. Race - Ame Black, Whi		n,
9	or its	F	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 🛣	No	1		212 No	Specify		ricari, etc.)	ŀ	Specify:	ie, eic.	
21215-0036	ural',	d by	3 Widowed 4 □ Divorced	Year or Dates:				-A-110					Wh	iite	
5-(72 h	Completed	15. Decedent's I (Specify only highest g			16a. Deced	kind of w	ual Occupa rork done di use retired)	uring mo:	st of working	ng	16b. K	(ind of Business	/Industry	
121	within the n	m m	Elementary/Secondary (0-12)	College (1-4or	5+)							0	Uama		
	Hygie ther nt, II	e Co	12 17. Father's Name (First, Middle, Las	(t)		Home	маке	: L	18. Moth	er's Name	(First, Middle		1 Home		
Maryland	12 should be filed within hand Mental Hygiene. 7 ie marked other then "traumatic event, the Men	00	William Ernest								lace Di				
2	should mark mati	٦	19a. Informant's Name/Relationship			19b. Mailir	ng Addre						or Town, State,	Zip Code)	
S	nd 2 :		Mary Wendehack/	Daughter		2403	Lizb	ec Co	urt	Croft	on, MD	211	14		
ē,	s 1 a f Hea itam othe		20a. Method of Disposition	lace of Disno	sition (N	ame of	1		ate		ocation - City or	Town, Sta	(e		
Ë	Page ient o nt: if ry or		1 Deurial 2 Cremation 3 4 Donation 5 Other (Spec		Me	eme <i>tery, crer</i> Park morial	Iawn Par	k	1	04/07	/2006	Rock	cville,	MD	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Depertment of Health and Menat Hygiene. Important: if item 27 ie marked other then "natural", or itema 23a or 28a-1 ehow erry folyer or other traumatic event, the Madical Exartinat be codified at ADE.		21. Signature of Funeral Service Lice	ensee		22	. Name a	and Address	s of Facil				is Funer		me
m	Depermit Deper Impor eny in		1 Com	4		1	6000	Anna	poli	s Roa	d Bowi	e, M	D 20715	5	
	ng → ng -		23a. Part1. Enter the disease, or co- shock, or heart failure. List on	mplications that caused y one cause on each li	the death	h. Do not ent	er the mo	ode of dying	, such as	s cardiac o	r respiratory a	rrest,		Approx Interva	Betweeff
	Physician		Immediate Cause (Final disease or condition	DAS	uma	ortia								Onset	and Death
	/Medical		resulting in death)	Dye to (or as	a conseq	uence of):									
	Examiner		Sequentially list conditions, if any, leading to immediate	b											
<u> </u>	De is	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a conseq	uence of):									
	and and I-tran	хаш	that initiated events resulting in death) Last	cDue to (or as	a consed	neuce of).									
60,	cate be executed physicien and the burial-transit	a E													
68760,		dical		d											
	death certif e attending id for use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregna	incy							23d. Date of de	livery	
Вох	atter after for u	clar	in the past 12 months?	1□Live birth 4□Pregnant a			Ectopic Other (pregnancy s <i>pecify)</i>					Month	Day	Year
P.O.	the d by the	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown											
	requires that the been signed by th hould be detache	by P	Part II. Other significant conditions	contributing to death b	ut not res	ulting in the u	nderlying	cause give	n in Part	I.	23e. Did	obacco	use contribute t	o the cause	of death?
Records,	w require been sig should b	ed D									10	Yes 2	□No 3□P	robably	Inknown
တ္တ	> 11 W	plet									24a. Was		24b. Were a	utopsy find	ngs available of cause of
æ	The i	Completed									auto perfe	ormed?	death?		
ita		Be C	25. Was case referred to medical examiner?						26. Plac	e of Death	(Check only				
f V	Physician: this certific ral director,	To	1 Yes 2 No	Hospital: 1 Anpatie	ent 2 🗆	ER/Outpatier	nt 3 🗆 🛭	OOA Othe	HT 4□ N	lursing Hor	ne 5□Res	dence	6 □Other (Spe	cify)	
0 _	ng Pt fter th		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time o		28c. Injury Work			28d. Describe	how inju	iry occurred		
sio	Attending r death. ector: After by the fune	catl	2 Accident investigate 3 Suicide 6 Could not				М	1 🗆 Y	/es 2□						
Division of Vital	or Att	Certification:	4 Homicide determine	28e. Place of In building, el	ury - At he c. (Specif	ome, farm, str y)	eet, facto	ory, office		1	28f. Location (City or To	Street ai wn, State	nd Number or A e)	lural Route	Number,
	pitai ours a erai C	ပိ	29a. Certifier 1 Certifying	Physician: To the best	of my kno	uuladaa daat			a data a	nd place 3	and due to the	20112012) and manner o	a stated	
	To the Hospital or Attending Physikin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical	(Check only 2 Medical Ext	aminer: On the basis of	f examina	tion and/or in	vestigatio	on, in my op	inion, de	ath occurre	ed at the time,	date an	d place, and du	e to the cau	use(s)
	o the	Me	29b. Signature and title of certified	f			2	9c. License					ate signed (Mon	th, Day, Ye	ar)
	- 5 - 0		Vel Well	cons he	b			02	480	34		0	4-03-	200	6
			30. Name and address of person wh	o completed cause of	leath (Iten	n 23a) (Type.	Print)		1	ŧ	1 ,	10	2		
				ersen MI.)	AA	MC		An	Maga	14 M	d	21401		
12	Sta		31. Date filed (Month, Day, Year) APR 0 5 20	2. Registr	ar's Signa	ature									
1	Regist	ar	AFR U J Z	JUD JUD	13	450									

		For State of Maryland / State Registrar		artment of H		•	giene Rog. No.	06	2895
Physicia		1. Decedent's Name (First, Middle, Last) Genevive (NMN) Dattilio				2. Date of De Month APRIL	Day	Year	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give street and number)			Location of Death			2006 County of Death	1:15 P "
Funeral Director		RAVENWOOD LUTHERAN VILLAGE 5. Social Security Number 6. Sex 7. Age (In yrs. last to 219–20–1076 1 D M 2 F 80	<i>birthday)</i> Yrs.	HAGERSTO If Under 1 Year Months Days	WN If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da March		Cou	N place (State or Foreigr intry) Vland
D		Usuel Residence of Decedent 10a. State 10b. County 10c. City, To	own or Lo	cation		rateri			10d. Inside City Limits
death with the Maryland ms 23a or 28a-f show froust be notified at	ector	Maryland Washington	Hage	erstown					1 ☐ Yes 2X No
with to	Ö	10e. Street and Number 13319 Herman Myers Road		10f. Zip Code	1742		10g. Citize	en of What Cou	intry?
p 22 23	d by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ◯ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:		Vas Decedent of H I Yes, specify Cuba		pecify Yes or No Rican, etc.)	1 _	4. Race - Ameri Black, White	
Maryland 21215-0036 to 2 should be filed within 72 hours all the and Mental Hygiene. 27 is marked other then "natural", or traumatic event, the Medical Examitraumatic event, th	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. L	lent's Usual Occup kind of work done o DO NOT use retired NEMaker	ation during most of work f)	king		d of Business/Ir	esidence
d 2 s filed v s Hygie other t	Be Co	8 17. Father's Name (First, Middle, Last)	noı	ienakei	18. Mother's Nam	e (First, Middle,			estaence
ylar ould be Menta Marked	ToB	Napolean Bonapart Pryor				a M. Smi			
Mar nd 2 sh lth and 27 Is m		19a. Informant's Name/Relationship (Type, Print) Michele A. Parks (daughter)		g Address (Street a					
altimore, mit. Pages 1 ar partment of Hea portant: If liem 3 y injury or other		20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Removal from State	of Disportery, cren	sition (Name of natory or other plac	e)	Date	20c. Loca	ation - City or T	own, State
altin		. 4 □Donation 5 □ Other (Specify) ROSE 21. Signature of Funeral Service Licensee		. Name and Addres		2-2006			Maryland
Bal permi Depar Impo		Deuclar A. Xing	. 13	31 Easte	rn Biva.	N. Hage	ersto	wn Mary	Land 21/42
Physician		23a. Part 1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			_		rest,		Approximate Interval Between Onset and Death
876(cate be chysicize the burner)	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the cause of the cause). Due to (or as a consequence of the cause). Due to (or as a consequence of the cause).	OFT e of):	16 57	EN DSI	S			
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death certificate the Funeral Director: After this certificate has been signed by the attending to the Funeral Director: After this certificate has been signed by the attending to completely filled in by the funeral director, page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 monutes? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown		Ectopic pregnancy Other (specify)			23	d. Date of deliv	ery Day Year
dS, Puires that	d by Pr	Part II. Other significant conditions contributing to death but not resulting PREMINIA, ATMAL FIBR							the cause of death?
aw requires been 2 shou	Completed	GASTPOINTESTINAL BL				24a. Was		24b. Were auto	opsy findings available
Vital Rec	Сош	UPINARY TRACT IMFY	CTÍ	ON		perfo	rmed? 2 No	death?	2□ No
Vita sician s certifi	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Outnation	t 3□ DOA Othe	26. Place of Deat	th (Check only o		D045/0	4.1
n of ng Phy fter this	\vdash		. Time of Injury	28c. Injury Work		28d. Describe h			(y)
Division of Vital Records, to the Hospital or Attending Physician: The law requires the within 24 hours after death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be completely filled.	Certification:	2 Accident 3 Suicide 4 Homicide Accident investigation 28e. Place of Injury - At home, building, etc. (Specify)	farm, stre		Yes 2□No	28f. Location (S City or Ton	Street and vn, State)	Number or Run	al Route Number,
Mospit 24 hour 8 Funers etely fills	edical (29a. Certifier (Check only one) Certifying Physicien: To the best of my knowled 2 Medicel Exeminer: On the basis of examination and manner stated.	lge, death and/or inv	occurred at the timestigation, in my op	ne, date and place, pinion, death occur	and due to the cred at the time,	cause(s) a date and p	nd manner as s lace, and due t	stated. o the cause(s)
To the within To the compl	Me	29b. Signature and title of certifier		29c. License			29d. Date	signed (Month,	Dey, Year)
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Stat Registra		31. Date filed (Month, Day Year) 2006 32. Segistrar's Signature	An	ade i					

			1 - For State Registrar	State of Maryland			of Health a			giene 2000 0 6	e contract de la cont	2896
			1. Decedent's Name (First, Middle, Last)		_				Date of Dea		Year	3. Time of Death
13	Physici /Medic		Henrietta E	lizabeth Da	atche	r		Aı	oril	5, ^{Day} 006		7:25ртм
	Examin		4a. Facility Name (If not institution, give	street and number)			wn, or Location	of Death		4c. County o		
		£	Waldorf Healthca			Wald				Charle		
2	Funeral Director		379 40-0733	7. Age (In yrs. Ia 3 M 2 T F 87 yrs	st birthday) Yrs.	If Under 1 Y Months D	fear if Under lays Hours	Min	Date of Birth (Month, Day e b •	10°,1919	9. Birthpla Countr Mai	ce (State or Foreign y) y land
	D .		Usual Residence of Decedent 10a. State 10b. County	10c City	Town or Lo	cation					10	d. Inside City Limits
	anyla sho	7	Md. Charles		dian						1.0	1X Yes 2 □ No
	the N	ect	10e. Street and Number	, III	dian	10f. Zip Co	nde			10g. Citizen of Wi	nat Count	v?
	with	ā		Lana		2064				USA	iat obain	,.
	eath	era	- 1	Lane 12. Was Decedent Ever in U.S	3. 13.			igin? (Specif	v Yes or No-		- America	n Indian,
10	fter of the rest	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 22 No			t of Hispanic Ori Cuban, Mexicai		an, etc.)		, White, e	
930	urs a	b	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X☐	Mo Specify:			Specify:]	Blac	k
21215-0036	2 ho	ted	15. Decedent's Edu	cation	16a. Dece	dent's Usual C	ccupation	t of working		16b. Kind of Bus	iness/Indu	ustry
21	hin 7 B. "n Mod	pie	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use r	done during mos etired)	a or working				
7	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or Itema 23e or 28e-f show ent, Ite Medical Examinat must be notified at	Compieted by Funeral Director	12	0	Cafe	teria	Manag			Local G		nment
P	al Hy al Oth	Be	17. Father's Name (First, Middle, Last)				18. Moth	er's Name <i>(F</i>	First, Middle,	Maiden Sumame)	
<u>ya</u>	should be find Mental Is marked of umatic ave	2	John Bransome						ınger			
Maryland	and le m		19a. Informant's Name/Relationship (Ty			•				r, City or Town, S		•
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Itema 23a or 28a-f show any injury or other traumatic avent, Ite Medical Examinat must be rediffed at ance.		Thomas Datcher/							omfret,		
Baltimore,	Jes 1		20a. Method of Disposition 1 🗖 Burial 2 🗆 Cremation 3 🗆 F	Removal from State	m <i>etery</i> , c <i>r</i> er	sition (Name of natory or othe	r place)	Date		20c. Location - C		
Ē	Pag ment ant: ury		4 Donation 5 Other (Specify)	Mt.			Cem. 4			Nanjemo		
ga II	permit. Departr Imports any inju		21. Signature of Funeral Service Licens	0 1 /						Funeral		
	705 # g		Chrylle &	BUGOR						dorf,Md		
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Que to (or as a consequence to or as a consequence to the consequen	notice of):		words					Approximate interval Between Onset and Death
,0928	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequent.	ence of):							
.O. Box 6	res that the death certificationed by the attending place detached for use as to	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3[Ectopic pregr				23d. Date Mont		y Day Year
ص ّ	that hed b	by Pi	Part II. Other significant conditions co	ntributing to death but not resu	lting in the u	nderlying caus	se given in Part I	1.	23e. Did to	bacco use contrit	oute to the	cause of death?
Records,	quire n sig uld bi	a pe							1 🗆 Y	es 2 No	3 ☐ Proba	bly 4 Unknown
၀	aw requir s been si 2 should	Completed							24a. Was		ere autop	sy findings available
ď	The law ate has page 2 :	E							autop perfor 1 Yes	med2 de	ath?	pletion of cause of □ No
	an: tifica tor, p	0	25. Was case referred to medical				26. Place	e of Death ((Check only o			
<u>></u>	Physician: The la this certificate ha ral director, page 2	To B	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatier	nt 3 DOA	100	4		lence 6 🗆 Other	(Specify)	
	<u>r</u> = ē		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c.	Injury at Work?			ow injury occurre		
Division	Attending r death.	Certification:	1 Natural 5 Pending 2 Accident investigation		,,	М	1 Yes 2	No				
<u> </u>	r Atte	titic	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, st	reet, factory, o	ffice	281	Location (S	Street and Number	r or Rural	Route Number,
	talor rsafte alDir	Cer										
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical		rsician: To the best of my know iner: On the basis of examinati and manner stated.								
	To the within To the comp	Me	29b. Signature and title of certifier	10		29c. L	icense number			29d. Date signed	(Month, D	ley, Year)
	NO		114	Han		D	2257	4		416	106	9
/			30. Name and address of person who of							110	1	
/	(4)		Timonthy Pace,M	D.,12070 01d	Lin	e Cent	er, Wa	aldor	f, Md	. 20604	+	
	Sta	ite	31. Date filed (Month, Day, Year) APR 0 7 2006	32. Registrar's Signat	ure							

DHMH 17 Rev 1/2001

, ,	1 -		State of Maryland / Department of He State of Maryland / Department of He Registrar Certificate of Department	alth and Mental H	_	12897
	Physici /Medio Examir	al	1. Decedent's Name (First, Middle, Last) Murphy Nathaniel Dixon Sr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Lo	2. Date of Death	h 38 2006 4c. County of Dea	7:00H M
	Funeral Director			Hours Min. 8. Date of B	Prince Ge irth (ay, Year) 9. 8i 9. 8i 9. 8i 9. 8i 9. 8i	corge's rthplace (State or Foreign country) shington DC
	th the Marylan or 28a-f show	Director	10a. State 10b. County 10c. City, Town or Location MD Prince George's College Park 10e. Street and Number 10f. Zip Code		10g. Citizen of What C	10d. Inside City Limits ★☆Yes 2 No Country?
036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Medical Evans as most the Lost fied at	by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes \$4☐ No	anic Origin? (Specify Yes or N Mexican, Puerto Rican, etc.) Specify:	United Sta lo- 14. Race - Am Black, Wh Specify: B1	erican Indian, ite, etc.
Maryland 21215-0036	I within 72 houiene. Item "naturitie Medical I	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 15. Decedent's Education (Give kind of work done durlife. DO NOT use retired) Laborer	on ing most of working	16b. Kind of Business	s/Industry
ryland 2	nould be filed if Mental Hyg narked other natic event, I	To Be C	17. Father's Name (First, Middle, Last) Jasper Dixon	8. Mother's Name (First, Middle Unknown	e, Maiden Surname)	7. 0.41
Baltimore, Mai	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, it is Mudical Examment may be confied at 2000.		19a. Informant's Name/Relationship (Type, Print) Bernette Dixon / Daughter 19b. Mailing Address (Street and State) 5113 Lakeland Relationship (Name of cametery, crematory or other place) 4 □ Donation 5 □ Other (Specify) 10b. Place of Disposition (Name of cametery, crematory or other place) Metropolitan Crema: 22c. Name and Address 2617 Portray Address	d College Park	MD 20740 20c. Location - City o Alexandria	r Town, State Va
	Fnysician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	such as cardiac or respiratory		Approximate Interval Between Onset and Death Mours
8760,	ate be executed hysicien and the burial-transit	ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):			years vulc moun
.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (specify)		23d. Date of de Month	elivery Day Year
ords, P	requires that een signed b nould be deta	ted by Pl	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given		tobacco use contribute	to the cause of death? Probably 4 Unknown
tal Rec	an: The law tificate has b tor. page 2 st	Be Completed	25. Was case referred to medical	24a. We aut per 1 □ Yes	opsy prior to death? 2 No 1 □ Ye	autopsy findings available completion of cause of s 2 No
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires within 24 hours after death. To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be	은	Address of Death Accident Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other. Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other. 2 Manner of Death	4 ☐ Nursing Home 5 ☐ Re		ecify)
Divis	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	al Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time,	City or T	(Street and Number or Fown, State)	
		Medical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opin and manner stated. 29b. Signature and title of certifier 29c. License in	ion, death occurred at the time	e, date and place, and du 29d. Date signed (Mon	ne to the cause(s)
2)	ЭC		Jew / Lew MP)/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven Remsen 575 Hain Street Ste	7849 +351 Laurel	3/30/0 Hd 2070	07
	Sta Registi		31. Date filed (Month, Day, Year) APR 0 7 2006 32. Registrar's Signature			

			For State Registrar	State of	Marylan	d / Depa <i>Cer</i>	artment of H tificate of L	lealth and Death	d Mental Hy	giene Reg. No.	0.6	12899
	Physici		1. Decedent's Name (First, Middle, La Freddy Francisco						2. Date of De Month April	3, Day 200	Year	3. Time of Death 4:00 p M
	/Medio		4a. Facility Name (If not institution, gi Maryland House of Con			,	4b. City, Town, or Jessup			4c. Cour	ity of Death	1
Ī	Funeral Director				7. Age (<i>In yrs. I</i> .		If Under 1 Year Months Days	If Under 24 I	Hrs. 8. Date of Bir Min. (Month, Da Dec. 4,	th	9. Birth	place (State or Foreign htry) ican Republic
	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "naturel", or iteme 23a or 28a-f show event. The Medical Examere must be notified at	Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Prince 10e. Street and Number 11342 Cherry H: 11. Marital Status		s	302	sville 10f. Zip Code 20705	ispanic Origin		10g. Citizen o	of What Cou	epublic
1215-0036	within 72 hours after c sne. then "naturel", or Iter n Medical Examina	Completed by Fun	1 № Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's E (Specify only highest g. Elementary/Secondary (0-12)	Armed For 1	2 X No e ates:	16a. Decec (Give life. I	f Yes, specify Cuba MC Yes 2 □ No tent's Usual Occupa kind of work done of DO NOT use retired Orer	Specify: DC			Business/In	Racial
yland 2	D 0 5	Be Co	17. Father's Name (First, Middle, Las	t)		Lab	orer		Name (First, Middle	, Maiden Sum) II
Maryia	permit. Pages 1 and 2 should be fite Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other treumatic eventance.	L _O	Miguel DeLeon 19a. Informant's Name/Relationship Ramon O. Escarfu				-	and Number of	rina Liria 	er, City or Tow		Code)
Baitimore, I	Pages 1 and and of Healing it: If Item 2 y or other		20a. Method of Disposition 1 ⊈Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		State	lace of Dispo emetery, crem	sition (Name of natory or other plac ven Cemeter	e) Ap	Date ril 10,	20c. Location	n - City or T	own, State
Baitil	permit. F Departme importar any injur		21. Signature of Funeral Service Lice		10000			-				g, MD 20901
8/60,	death certificate be executed By American and American and for use as the burial-transit	dicai Examiner	23a. Port. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <u>Cardic</u> Due to (b. <u>Liver</u> Due to (c.	aused the death ach line. Orespir or as a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequ	atory uence of):		g, such as car	diac or respiratory a	rrest,		Approximate Interval Between Onset and Death 5 Minutes Months
O. Box 6	aath certif attending for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		inth 2 ☐ Fetal ant at time of de	death 3	Ectopic pregnancy Other (specify)				Date of deliv Month	ery D <i>a</i> y Year
cords, P.	n requires that the de been signed by the should be detached	b	Part II. Other significent conditions Coagulopathy, And									he cause of death? pably 4 ⊊ Unknown
Ĕ	The lay ate has page 2	Completed							1 ☐ Yes	psy prmed? 2 🖾 No	prior to co death? 1 \(\text{Yes}	opsy findings available mpletion of cause of
rvital	.e. ≥	To Be	25. Was case referred to medical examiner? 1★ Yes 2 No	Hospital:	npatient 2	ER/Outpatien	t 3 DOA Othe		Death (Check only only only only only only only only		ther (Specia	(y)
sion of	al or Attending Ph safter death. I Director: After th d in by the funeral		27. Manner of Death 1 Xslatural 5 Pending 2 Accident investigation	on	of Injury h, Day Year)	28b. Time of Injury	28c. Injun Work	/ at	28d. Describe			
DIVISION	tel or Att s after de al Directo ed in by t	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	200. Place	of Injury - At ho ng, etc. (Specily	me, farm, str	eet, factory, office		28f. Location (City or To		mber or Run	al Route Number,
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier 1 ☐ Certifying P (Check only one) 1 ☐ Medical Exa	hysician: To the miner: On the ba and mann	asis of examinat	wledge, death ion and/or in	n occurred at the time vestigation, in my of	ne, date and p pinion, death o	lace, and due to the occurred at the time,	cause(s) and date and place	manner as s e, and due t	stated. o the cause(s)
	V with	Σ	29b. Signature and title of certifier	The			29c. License D6214			29d. Date sign		
			30. Name and address of person of Gedion Atnafu, I					ections	Rd, Jess	up, MD	20794	
	Sta Registi		31. Date filed (Month, Day, Year) APR 1 0	2006	egistrar's Signa	the A	medi					

Physiciar Medical Examin

Funeral Director

Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

1- For State Registrar			partment certificate				,	_	Rea. Nr	2006)	12900
1 Decedent's Name (First, Midd	le,Last)	Darco						2. Date of De Month April 5, 2	ath Day			3. Time of Death 6:01
Bernardo 4a. Facility Name (if not institutio		Dargo Inumber)		4b. City	, Town, or	Location of	Death	7 tpin o, 1	-	c. County of E	eath	
495 Oxon Hill				Oxo	n Hill					Prince Ge	orge'	s
5. Social Security Number	6. Sex	1	s. last birthday	/) If Ur Mor	nder 1 Year		T .	-			. Birth Cour	place (State or Foreig
219-45-9649	1 XX M 2	_F 53	3	Yrs.	nths Days	Hours	Min.	April	15,	1952		lippines
Usual Residence of Decedent 10a. State 10b. County		100.0	City, Town or L	ocation							- T	10d. Inside City Limits
												1 Yes 2 XX No
Maryland Prince 10e. Street and Number	George's	Pt	. Washir	9	Zip Code				10a C	itizen of What	Count	rv?
9802 Tribonian Dr	rive				20744				USA			
11. Marital Status		Decedent Ever in	n U.S. 13	Was Dece	dent of His	panic Origin	n? (Spe	ecify Yes or I		7	meric	an Indian, Black,
1 Never Married 2 XXN	larried Arme	d Forces?				, Mexican, I				White, e	tc.	
3 Widowed 4 Div	vorced If Yes, Give		1	Yes	2XX No	specify:				Specify:	Fil	Lipino
15. Decedent's Education (Spe		grade completed	1) 16a. Dece	edent's Usu	al Occupati	ion (Give ki	nd of w	ork done	16b	Kind of Busin	ess/In	dustry
Elementary/Secondary (0-12)		e (1-4 or 5+)		t of working	glife. DO N	OT use reti	red)					
	2 year	.S	Elec	tricia		40.44-11		Cinc Adda		Electric	al.	
17. Father's Name (First, Middle Angel P. Dargo	, Last)							(First, Middle a Taoade		n Surname)		
19a. Informant's Name/Relations	ship (Type, Print)		19b. Ma	ailing Addre	ess (Stree	t and Numb	er or R	ural Route N	umber,	City or Town, S	State,	Zip Code)
Victoria Dargo /	Wife									Maryland		0744
20a. Method of Disposition			b. Place of Di			netery,		Date	200	Location - Cr	ty or T	own, State
	n 3 XX Remov		inco Est			Cem.	04/1	1/2006	Q	uezon Cit	zy.	Philippines
4 Donation 5 Other S 21. Signature of Funeral Service	Section 1999 to 19	-		22. Name e	nd Address	of Facility	Cor	orgo P		s Funera	•	
Bune 6: 11	h			6160	Oxon H	ill Roa					2074	
23a Part I. Enter the disease, of failure. List only one cause		at caused the de	eath. Do not en	ter the mod	le of dying,	such as car	rdiac or	respiratory a	rrest, sl	hock, or heart		Approximate Interva Between Onset and
Immediate Cause (Final disease	B. # 147 - 1	Injuries										Death
or condition resulting in death)	Due to (or	as a consequenc	ce of):									
Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequenc	e off:									
cause. Enter Underlying Cause (Disease or injury that initiated												
events resulting in death) Last	Due to (or	as a consequenc	ce of).									
	d		-									
UNPENDED	AMEND											
IF FEMALE: 23b. Was decedent pregnant in	he	es, outcome of p	oregnancy 2	Fetal dea	ıth 3	Ectopic	pregnar	ncy	2	3d. Date of de Month	livery Da	ay Year
past 12 months?	, , , , , , , , , , , , , , , , , , ,	regnant at time o		Other (S								
	9 U	nknown										
Part II. Other significant condi	tions contributir	ng to death but n	ot resulting in	the underly	ing cause g	given in Par	t I.					ne cause of death?
									opsy	prio	r to co	opsy findings available Impletion of cause of
									formed		th? Yes	2 No
25. Was case referred to medica	al					of Death (Check o	only one)		^ _1 -		
examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatien 2	ER/Outpa	itient 3	DOA	Other ₄	Nursing	Home 5	Resi	dence 6	Other:	Scene
27. Manner of Death	28a. D	ate of Injury lonth, Day,Year) ND:	28b. Time			ry at Work?				njury occurred		
j Per	idirid .	5, 2006	05:56	·.	11	Yes 2	No					
3 Suicide 6 Cou	ld not be 28e. I	Place of Injury - A		street, facto	ory, office b	ouilding, etc.		or Town	State)			al Route Number, City
4 Homicide		cify) Intersta				-				asas, Oxon		
	hysician: To the											
one) 2 Medical Ex	aminer: On the ba	isis of examination	on and/or inve	sugation, in	Tity Ophilion	i, death occ			to and h	ridoc, aria auc		Caaso(s)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death certificate has been signed by the attending physician and dompletely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Division of Vital Records, P.O. Box 68760,

State Registrar APR 0 6 2006

Theodore King MD.

32. Registrar's Signature

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

ORIGINAL

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

April 5, 2006

DHMH 17 Rev 1/2001 OCME 10/2003

State of Maryland / Department of Health and Mental Hygiene - Stata Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** April 7, Charles Edward Dixon 2006 4:50 A. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 14411 Candy Hill Road Upper Marlboro Prince George's If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F Director 220-32-5690 74 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits than "natural", or itema 23a or 28e-f show the McJidal Examinational Le notified at 1 ☐ Yes 2 📉 No MD Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ā 20772 14411 Candy Hill Road USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritaf Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify ρ 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 excavating, construct. excavating company owner other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ies 1 and 2 should be fill of Health and Mental H Charles C. Dixon Maude Watson 19a. Informant's Name/Refationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Rachel Dixon, wife 14411 Candy Hill Rd., Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If Ite
any injury or ott 1 Burial 2 Cremation 3 Removal from State 4 □Donation 5 □Other (Specify) Metropolitan Crematory 04-08-06 Alexandria, VA 21. Signature of Funeral Service Licensee, 22. Name and Address of Facility William I 20736 Rausch Funeral Home, P.A., Owings, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestine /Medical Due to (of as a consequence of): Examiner 26 Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a cons equence of) physicien and s the burial-transit Division of Vital Records, P.O. Box 68760, Physician/Medicai attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificete ha lirector, page 2 1 Yes 2 No 25. Was case referred to medical 26. Pface of Death (Check only one) examiner? Other 4 Nursing Home Massidence 6 Other (Specify) Hospital: 1 Yes 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural s after de. **I Director: Alte 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 (Yertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D-0062908 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) Tina Lee, M.D., 225 Town Square Dr., Ste. 2, Lusby, MD 20657

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Registre 's Signature

1 2005 ▶

			1 - For State Registrar	State of Marylar	nd / Depa		lealth and		_	12902
36	Physici	ş.	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Yea	3. Time of Death
	/Medi		ANNIE MAE	ENGLISH					28, 2006	2195 M
1	Examir	ner	4a. Facility Name (If not institution, give s			4b. City, Town, or			4c. County of D	
			410 MILLWOOF DRI 5. Social Security Number 6. Sex		last birthday)	CAPITOL If Under 1 Year	If Under 24 Hrs		Prince	Birthplace (State or Foreign
*	Funeral Director			M 2XIF 63	Yrs.	Months Days	Hours Min	s. 8. Date of Birth (Month, Day, JULY 12	1942 V	Country) IRGINIA
	yland how		10a. State 10b. County	10c. Ci	ty, Town or Lo	ecation				10d. Inside City Limits
	Ba-f	Director	MD PRINCE GE	EORGE'S	CAPITO	L HEIGHTS				1X Yes 2 □ No
	or 24	Dire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?
	e 23e		410 MILLWOOF DRI		C 123	20743	innania Orinia? ()	Const. Van antila	U.S.A.	- don to die
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Iteme 23e or 28e-1 ehow the Madical Examinar must be rediffed at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		was Decedent of H If Yes, specify Cuba		Specify Yes or No- rto Rican, etc.)	Specify:	merican Indian, hite, etc. BLACK
5-0	72 ho	eted	15. Decedent's Educ (Specify only highest grade	cation	16a. Dece	dent's Usual Occupa	ation	orking	6b. Kind of Busine	ss/Industry
21	I within 72 ho iene. r then "natur the Medical	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)			
121	D D =		17. Father's Name (First, Middle, Last)	l yr	ACC	OUNTANT T			GOVERNM	ENT
Maryland	be d la be	To Be	PERCY EVERSON				MATT		[
	1 and 2 should Health and Mer tem 27 Is marks		19a. Informant's Name/Relationship (Ty), ALEXANDER ENGLI	pe, Print) SH/HUSBAND				APITOL HEI		a, <i>Zip Code)</i> YLAND 20743
Baltimore,	S = = 0		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	cemetery, crer	sition (Name of natory or other plac ANS CEME)	. 1		Oc. Location · City	or Town, State
alti	프로로를		21. Signature of Funeral Service License					. B. JENK		
Ω_	Depa Impo		1 K.D.M.	-hall	7	474 LANDO	OVER ROA	D LANDOVE	R,MARYLAN	ID 20785
	Physician /Medical		23a. Part 1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Arterioso	lecti					Approximate Interval Between Onset and Death
	Examiner		1	Due to (or as a consec	uence of):					
	cuted id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec	uence of):					
90,	ate be executed hysicien and the burial-transit		resulting in death) Last	Due to (or as a consec	uence of):					
68760,	physic the b	dlcal								
.O. Box 6	that the death certifical hed by the attending phy idetached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) No 9 \(\text{Unknown} \) Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of o	delivery Day Year
s, P	9 <u>1</u> 0 9	Ď	Part II. Other significant conditions con	tributing to death but not res	ulting in the ur	nderlying cause give	en in Part I.			to the cause of death?
Record	> 10 0	eted						24a. Was an		
al Re	The la ate has page 2	e Completed	25. Was case referred to medical					autopsy performe 1 🗆 Yes 2x	prior t death ☐ No 1 ☐ Y	autopsy findings available o completion of cause of ? es 25 No
of Vital		To Be	evaminer2-	ospital: 1 Inpatient 2	ER/Outpatien	t 3 DOA Othe	3F*	eath (Check only one) Home 5 Presiden		nacht)
οι	iding Phys th. After this funeral di		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		at	28d. Describe how		Decity)
sior	Attending ir death, ector: After by the fune	atlo	1 Natural 5 Pending investigation	(Month, Day 16a)	пцагу		Yes 2 □ No			
Division	al or Atten s after deat if Director: id in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specifical Control of the building) and the building of the build	ome, farm, stro y)	eet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
	To the Hospital or Atteni within 24 hours after deatl To the Funerel Director: completely filled in by the	edical (29a. Certifier 1 ☐ Certifying Phys (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or inv	n occurred at the time vestigation, in my op	e, date and plac pinion, death occ	e, and due to the cau curred at the time, dat	ise(s) and manner e and place, and d	as stated. ue to the cause(s)
	To the within 2	Me	29b. Signature and title of certifier	11 -		29c. License			d. Date signed (Mo	
•	(5)		Salvador /	hoster De	2	Hoos	5592	7 /	land:	29, 2006
	30. Name and address of person who pempleted cause of death (Item 23a) (Type, Print) SALVA dor Sylvester, 3001 Hospital Drive Clarely Mary Mand									Sland
	Sta Registr		APR 0 6 2006	32. Registrar's Signa	iture			0.		,

DHMH 17 Rev 1/2001

State Registrar

			1 - For State Registrar	State of I	Marylar		artmen rtificate				lental Hy	giene Reg. No.	006)	12904
	Dhycici	20	1. Decedent's Name (First, Middle, La	st)				·			2. Date of De	eath Day	Va	25	3. Time of Death
	Physici /Medi		Ruby Lucille	Eavey							APR	IL 8	, 20	ar 1216	4:10 AM
	Examir	er	4a. Facility Name (If not institution, giv Saint Joseph	Medica		iter				owso	n	4c. 0	County of D	Death 1 t i	more
	Funeral Director		214-30-21/1	Sex 7. 1 □ M 2 F	Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 09/28	av. Year)	1	Countr	ce (State or Foreign y) and
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ity, Town or Lo	cation							100	d. Inside City Limits
	Maryl	5	MD Baltim	ore		pperco								100	1 ☐ Yes 2 ☐ No
	the 28s	Director	10e. Street and Number			PPOLOC	10f. Zip	Code				10a Citiza	en of What	Countr	
	3a or		3216 Mt. Carme	ol Rd.			21	.155					JSA		, .
	deat	Funeral	11. Marital Status	12. Was Decede Armed Force	nt Ever in L	J.S. 13. \	-		spanic Orig	gin? (Spe	cify Yes or No Rican, etc.)		4. Race - A		
98	or its	F	1 Never Married 2 Married	1 Tes 2	No		Yes	11	Specify:	i, rueito	nican, etc.)		Black, W		
8	J within 72 hours after death with the Maryland jiene. I than "natural", or Items 23a or 28a-f ehow the Madical Examines must be notified at	d by	3 Widowed 4 Divorced	Year or Date	s: 								Specify: W	vnıt	ce
갼	n 72	Completed	15. Decedent's Education (Specify only highest graduation)	ducation ade completed)		16a. Deced	dent's Usua kind of wor DO NOT us	k done d	lurina most	of worki	ng	16b. Kind	d of Busine	ss/Indu	stry
12	withi iene. than	mo	Elementary/Secondary (0-12)	College (1-4d	or 5+)		stre		/			Clo	thin		
ğ	illed Il Hygir other	Be C	17. Father's Name (First, Middle, Last,)		bean	BCLC		18. Mothe	r's Name	(First, Middle			19	
<u>la</u>	ould be Mental arked c	To B	Elisha C. Dor	sey					An	ne (C. Wea	ver			
4	and and and and and and	ij	19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address	(Street a	nd Numbe	r or Rura	l Route Numb	er, City or	Town, Stat	e, <i>Zip</i> C	ode)
	1 and 2 Health tem 27 l		Paul E. Eavey	Husban					rmel		. Uppe				
0	ges 1 t of H if ite or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from Sta	te	Place of Dispo cemetery, cren	natory or of	ther place			ate		ation - City		
Baltimore,	t. Pa ntmen rtant: njury		4 □ Donation 5 □ Other (Specif		Ca	rroll							pste		MD
Bal	permit. Pages Department of t important: If ite eny injury or of		21. Signature of Funeral Service Licer	1500							ne Fu				
			23a. Part 1. Enter the disease, or com	plications that caus	M 00						t. Har		ead,		21074
,	Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. CONGE	n line.	E HEA								l Ir	nterval Between Onset and Death
	Examiner		0			CARDI	OMYO	PATH	4Y						
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	as a consec	quence of):									
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	V		ARTER	Y DI	SEAS	3E						
8760,	icate be executed physicien and s the burial-transit	區	1	Due to (or a	as a consec	quence or):									
687	icate phys s the	edlcal		d			_							-	
P.O. Box	that the death certificate be executed the death certificate be executed to detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcon 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	ıl death 3 □	Ectopic pre Other (spe					23	d. Date of e	delivery Di	
S,	requires that the een signed by th hould be detache	y P	Part II. Other significant conditions of	ontributing to death	but not res	sulting in the un	derlying ca	use give	n in Part I.		23e. Did to	obacco use	contribute	to the	cause of death?
rds	w requires to the second secon	d be	END STAGE RENAL	DISEASE							101	res 2	, No 3□	Probab	ly 4 □Unknown
Division of Vital Record	> 0 0	Completed									24a. Was		24b. Were	autops	y findings available
Ĕ,	The law ete has b page 2 sl	E O								_	autor perfo 1 ☐ Yes	rmed?	death 1 🗆 Y	io comp	letion of cause of
/ita	Physician: this certificral director,	Be (25. Was case referred to medical examiner?					2000	26. Place	of Death	(Check only o	-			
5	hysto this o	ဥ	1 ☐ Yes 2 No	Hospital: 1X Inpa		ER/Outpatient			4 🗆 1901	sing Hon	ne 5 ☐ Resid	dence 6 (□Other (S	pecify)	
L L	After funer	lo l	27. Manner of Death 1 ☑ Natural 5 ☐ Pending		jury Day Year)	28b. Time of Injury		Work			8d. Describe I	now injury	ccurred		
S	Attending ir death. ector: After by the fune	Icat	2 Accident investigation 3 Suicide 6 Could not be		lniun - At h	ome, farm, stre	M factory		es 2□N		8f. Location (S	Etropt and	Numberos	Dum I C	
	after after Dire	Certification;	4 Homicide determined	building,	etc. (Specif	(y)	et, ractory,	Office		-	City or Tow	vn, State)	vumber or	Hurai H	route Number,
:	To the tooptial or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edical C	29a. Certifier 1 Certifying Ph (Check ordy one) 2 Medical Exam	ysician: To the be- niner: On the basis and manner	of examina	owledge, death tion and/or inv	occurred a estigation,	it the time	e, date and inion, death	d place, a	nd due to the o	cause(s) ar date and p	nd manner lace, and d	as state	ed. e cause(s)
	vithin 2 To the complet	Me	29b. Signature and title of certifier	//			29c.	License	number			29d. Date	signed (Mo	nth, Da	y, Year)
	X			Sw	<)	D 37	7254			4	181	06	>
V.	10	1	30. Name and address of person who	completed cause of	f death (Iten	n 23a) (Type, F	Print)								
	¥		BOON POH LIM,		7601	OSLER	DRI	VE,	TOWS	SON.	MARY	LAND	212	214	
	Sta Registr	٠.٠	31. Date filed (Month, Day, Year) APR 1 0 2	2006 32. Pro je	strar's Signa	iture	seeke	,							

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / Department of Health and M Certificate of Death	ientai Hy	Reg. No.	5 12905
	Dhunini		Decedent's Nama (First, Middla, Last)	2. Data of De		3. Tima of Daath
ı	Physici /Medic		Veronica Abong Ekenki	March	11 00	106 2021
	Examin	ier	4a Facility Nama (If not institution, give street end number) 4b. City, Town, or Lo	cation of Deat	h 4c. County	of Death
-	Funeral		5. Social Security Number 6. Sex , 7. Age (In yrs. last birthday) If Undar 1 Yaar If Undar 24 Hrs.	8. Data of Bir (Month, De	rth	9. Birthplaca (Stata or Foraign
	Director		N/A 1 M 2 F Yrs. Months Days Hours Min.	March 1	1,0006	Maryland
	pue *	· }	Usual Residence of Decedant 10a. Stata 10b. County 10c. City, Town or Location			10d. Insida City Limits
	Maryi -f sho	ঠ	Va Alexandria			1 X Yas 2 □ No
	or 28e	<u>§</u>	10e. Street and Number 10f. Zip Code		10g. Citizan of W	/hat Country?
	ter death with the Marylen ferns 23a or 28e-f show frer must be notified at	Funeral Director	5445 North Morgan St. Apt. 409 22312		USA	
	er de	nu	11. Marital Status 12. Was Decedant Evar in U.S. Armad Forces? 13. Was Decedant of Hispanic Origin? (Spi If Yas, specify Cuban, Mexican, Puarto	acify Yas or No Rican, etc.)	D- 14. Race Black	e - Amarican Indian, k, Whita, etc.
36	Jr. or	by	1 Never Married 2 Married 1 Yas 2 No H Yas, Giva 1 Yas 2 No Specify: Yaar or Datas:		Spacify:	Black
Maryland 21215-0036	within 72 hours efter death with the Marylend ene. than "natural", or frems 23a or 28e-f show fra Medical Expirition must be noriffed at	Completed by	15. Decedent's Education 16e. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work.	ina	16b. Kind of Bu	sinass/industry
121	within ene.	mpie	(Specify only highest grada completed) Elamantary/Secondary (0-12) Collega (1-4or 5+) (Giva kind of work done during most of works lifta. DO NOT usa retired)	•	11/4	
9	Hygin the mut.	ပိ	17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama	a (First, Middle	, Maiden Sumami	a)
an	lid be lentel ked o	To Be	Basil Ekenki Fomanka Dlivia A	zuta	Tange.	
lary	d 2 should the end Men 7 Is marked treumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Straat and Number or Rura	al Route Numb	er, City or Town,	Stata, Zip Code)
	ealth m 27		Olivia Tange/Mother 54516th Morgan St. A	7. 409 /	Alexandria	City or Town, State
Baltimore,	Peges nant of H		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	12/06	BA 4-	more MD
alti-		1	4 □ Donation SQOther (Specify) HOSD 174 □ 105P 174 □ 121. Signature of Funeral Sarvice Licensee 22. Nama and Address of Facility	A Hos	0,000	r Baitimner
ä	permit. Departi Importu any inj	70	Allente Thomaston 2401 W. Belveo.	ere A	BALTIN	10RC, 21215
H			234. Part1. Entar tha disaasa, or complications that causad the daath. Do not enter the mode of dying, such as cardiac of shock, or haart failure. List only one cause on each line.	or raspiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediata Cause (Final			
	Examiner		disaasa or condition resulting in deeth) a. Extreme trematurity Due to (or es a consequence of):			
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	ficate be axecuted physicien and as the bunal-transit	Examiner	Sequentially list conditions, if any, leading to immadiate causa. Entar Undarlying			
68760,	ysicient e buri	edical	that initiated avants Due to (or as a consequence of):			
			resulting in death) Last			
Вох	ath ce	lan/	d			
P.0.	y the g	Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			tributa to tha cause of death? 3 Probably 4 Unknown
	s that med b	by PI			Yes 2X No	On House,
Division of Vital Records,	law requiras that tha daath certif as been signed by the attending 9 2 should be datached for use a	bel			an autopsy ormad?	24b. Were autopsy findings available prior to completion of cause
Sec	= 0 N	Completed			12	of death?
al F	icate		Of Washington of an Alberta	+0	/\	1 ☐ Yes 2 ☐ No
<u>=</u>	s certif	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 1 No Other: 4 Nursing Ho		<i>one)</i> idence 6 ⊟Othe	er (Specify)
סר	g Phy ter this neral o				how injury occurre	
Siol	endin eeth. or: Af the fu	catic	2 Accident invastigation M 1 Yas 2 No	NA	(0)	0
Ξ	or Att	Certification:	4 Homicida determined determined 28a. Plece of Injury - At homa, farm, streat, factory, office building, etc. (Specify)		wn, State)	ar or Rural Routa Number,
_	To the Mospital or Attending Physician: The is within 24 hours after deeth. To the Funerel Director: After this certificate ha completely filled in by the funeral director, pege	CalC	29a. Cartifiar (Check only Medical Examiner: On the best of my knowledge, deeth occurrad at the time, date and place, and place is the desired form.			
	the H hin 24 the Fi	Medical	one) and manner stated.	00 01 1110 111110,		I (Month, Dey, Year)
	No To				2/11/	0 6
,		-	30. Nama and address of person who completed cause of death (Itam 23a) (Type, Print) Toy El Ballard	ND	3 11	J 4
	1000		Sinau Hospital 2401 W. Belvedere Ava. Balto. MD	21215		
	Sta	re	31. Data filed (Month, Day, Year) APR 2 5 2006 Ragistrar's Signature			
	Registr	dl	MINO O COOL KEEPEN FI			

DHMH 16 Rev 6/95

			State	of Maryland	•	nent of H cate of L			giene Reg. No.	6 1	2906		
	Physicia	1. Decedent's Name (First, M						2. Date of Dea	ath Day	Year	3. Time of Death		
J.	/Medica	vera Catheri					- Ch. T		11, 200	6 1	1:00 a.m.		
	. Examine	4a Facility Name (If not institution of the Julia Manor		-		4	b. City, Town, or L	rstown	,	ington			
	Funeral	5. Social Security Number	6. Sex	7. Age (In yrs. las		Inder 1 Year	If Under 24 Hrs.	8. Date of Birt (Month, Da			e (Stete or Foreign		
	Director	214-09-5109	1□M 2X0F	90	Yrs. Mo	nths Days	Hours Min.	April	3, 1916	Penns	sylvania		
	pue *	Usual Residence of Decedent 10a. State 10b. Cou		10c City	Town or Location				-	104	Inside City Limits		
	Maryle		hington								1 ☐ Yes 2 No		
	28e	10e. Street and Number	IIIIgton	па	gerstown 10	f. Zip Code			10g. Citizen of \	What Country	?		
	h witi	Maryland Was 10e. Street and Number 434 South Ed 11. Marital Status 1 Never Married 2 N	gewood Dri	ve		2	1740		USA				
	r deal	11. Marital Status	12. Was Dec	edent Ever in U,S.		ecedent of Hi	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No-		e - American ck, White, etc			
20	or it		farried 1 ☐ Yes If Yes, Gi	2 <u>⊠</u> No ive			Specify:	1110411, 010.)	Specify		ite		
21215-0020	72 hours after death with the Marylend natural', or items 23e or 28e-f show dical Examinat must be notified at	3 Widowed 4 Divor	dent's Education		16e. Decedent's	Heual Occupa	ation		16b. Kind of Bi				
215	nin 72		hest grade completed)		(Give kind o	f work done d OT use retired,	luring most of work	•					
21	giene giene pr tha	8	z) College (0	owner a	nd oper	rator	beauty shop - cosmetology					
nd	be file d oth	17. Father's Name (First, Midd	-					her's Name (First, Middle, Maiden Sumame) essie U. Faulder					
<u>\Z</u>	1 Men marke												
Maryland	permit. Peges 1 end 2 should be filed within 72 hours after death with the Manylen Department of Health and Mentel Hygiene. Department of Health and Mentel Hygiene important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other treumatic event, the Medical Examinat must be notified at once.	19a. Informant's Name/Relati Pat Padula -					nd Number or Rui						
Baltimore,	f Hea frem 2 other	20a. Method of Disposition		000	ce of Disposition	(Neme of		Date	20c. Location -				
E	Pege ient o int: If i	1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☑ Other	on 3 □Removal from (Specifyentombn	State	t Haven		-	4/15/06	Hagers	town.	Maryland		
alti	permit. Departr Importa sny Inju	21. Signature of Funeral Serv		2	22. Nam	e and Addres		INNICH					
<u> </u>	89 E 29	Tata	1////	unni	15	E. Wils	son Blvd.				nd 21740		
Lagy.		23a. Part1. Enter the disease shock, or heart failure. I	or complications that dist only one cause on e	caused the death.	Do not enter the	mode of dying	, such as cardiac	or respiratory ar	rest,	Int	proximate erval Between		
3	Physician	Immediate Cause (Final		<i>(</i>		A.S	ton	2.		Or	nset and Death		
O. L	Examiner	disease or condition resulting in death)	a	Coron			lery	1717	ease				
	DEEL			Due to (or a	s a consequence	pr):	. 0 1.			Ĭ			
	ificate be executed g physician end es the buriel-trensit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Ь	Due to (or a	s a consequence	of):	1 - \						
60,	be exe	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								į			
68760,	physic sthe	that initiated events resulting in death) Last		Due to (or as	s e consequence	of):							
Вох	The law requires that the death certificate be exacuted to be been signed by the attending physician end page 2 should be deteched for use as the buriel-trensit		d							1			
œ.	net the death cert d by the attending leteched for use e	Part II. Other significant cond	itions contributing to de	eath but not resulting	na in the underlyi	ng cause give	n in Part I.	23b. Did to	obacco use con	tribute to the	e cause of death?		
о. О	et the		•		,						ly 4 ⊅ Unknown		
Š,	signer the d												
Š	requi							24a. Was a perfor	in autopsy med?	availat	autopsy findings ole prior to etion of cause		
He	The law requires the sele has been signed page 2 should be considered.									of deet	th?		
	ortificete octor, pa		cal				26 Place of Doct	1 🗆 Y		1 □ Ye	es 2 No		
	Attending Physician: or death. ector: After this certific by the funeral director,		Hospital:	Inpatient 2 ER	3/Outpatient 3□	DOA Othe	26. Place of Deatl r: 4 ☑ Nursing Ho	me 5 Reside		or (Specify)			
0	ng Ph ter thi neral		28a. Date	of Injury 28 th, Day Year)	Bb. Time of Injury	28c. Injury Work		28d. Describe h					
Sio	tendil leath. tor: A the fu	2 Accident inve	stigation		М		'es 2□No						
	tal or Attending P rs efter death. al Director: After t led in by the funera	4 ☐ Homicide dete	rmined 286. Plece	of Injury - At home ng, etc. (Specify)	e, farm, street, fa	ctory, office		28f. Location (Si City or Town		er or Rural Ro	iute Number,		
	Hospital 24 hours (Funeral I) stely filled		ring Physician: To the	best of my knowle	dge, death occur	red at the time	a date and place	and due to the c	ause(s) and ma	nner es stater			
	To the Hospital or Attending Physician: The law within 24 hours efter death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	(Check only 2 Medic	al Examiner: On the ba	asis of examination ner stated.	and/or investiga	tion, in my opi	inion, death occurr	ed at the time, d	ate and place, a	nd due to the	cause(s)		
	To the vithin 2 To the comple	29b. Signature and title of certi	nun	~		29c. License	number	6 2	9d. Date signed		/		
		Janu		1		70	60 59	0	190	11(0)	~		
44	1-6	30. Name and address of person	on who completed caus	e of death (Item 23	Ba) (Type, Print)	1120	300	a)	4	0)	1740		
	State	31. Date filed (Month, Day, Yea	ar) 32. R	egistrar's Signature	9 ,		Hogo	15/0WM	, M	V	1 1 -		
	Registrar	A DO S	3 2006	10. a /.	1 Rose	41	U				İ		

DHMH 16 Rev 6/95

			1- For State of Mary		artment of Health			ene	h	12907
			Decedent's Name (First, Middle, Last)			2.	Date of Death	1	U	3. Time of Death
	Physici /Medio		Samuel Jay Frank				April 6	Day 2006	Year	8:07 P M
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location	of Death		4c. County	of Death	-1
			The Casey House		Rockville			Mont	gome	ry
	Funeral		16M 20E	yrs. last birthday)	If Under 1 Year If Under Months Days Hours	Min.	Date of Birth (Month, Day,	Year)	9. Birthp	place (State or Foreign
	Director		Usual Residence of Decedent	Yrs.		J.	une 9,	1927		NY
	and			: City, Town or Lo	cation				1	0d. Inside City Limits
	Mary	Ö	MD Montgomery	Potom						1 ☐ Yes 2 ☐ No
	the	Director	10e. Street and Number	FOLOM	10f. Zip Code		10	g. Citizen of V	Vhat Cour	ntry?
	3a o		11912 Gainsborough Road		20854					States
	death	Funeral	11. Marital Status 12. Was Decedent Ever		Was Decedent of Hispanic Or	rigin? (Specify	y Yes or No-	14. Race	- Americ	an Indian,
9	or Ite		1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No If Yes, Give		f Yes, specify Cuban, Mexica I □ Yes 2X No Specify		an, etc.)		k, White,	etc. White
8	iours irel',	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: WW	II	1 ☐ Yes 2 █ No Specify	у.		Specify	:	
5	within 72 hours after death with the Maryland ane. Then "neturel", or ltems 23e or 28e-f show is Medical Exeminer mast be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	lent's Usual Occupation kind of work done during mo-	st of working	1	6b. Kind of Bu	siness/In	dustry
12	within ne. hen	mp	Elementary/Secondary (0-12) College (1-4or 5+)	Infe. L	OO NOT use retired)		_			
2	be filed within 72 hours after death with the Marylan it all Hygiene. Id other than "neturel", or lieme 23a or 28e-f show or other than "neturel", or lieme 23a or 28e-f show event, Ins Medical Exeminational be notified at		17. Father's Name (First, Middle, Last)		Owner	hada Nama /F	irst, Middle, M	lestaur		
Maryland 21215-0036	ould be Mental arked o etic eve	To Be	Lewis Frank			da Goro		aideri Sumain	θ)	
Nary	2 should be and Mental is marked or reumetic ev		19a. Informant's Name/Relationship (Type, Print) Helen Frank - Wife		g Address (Street and Numb					Code)
re,	Health Health tem 27		20a. Method of Disposition 20	b. Place of Dispos	Gainsborough	ROAG]		Oc. Location -		wn State
Baltimore,	Pages ment of ent: If i		1 Burial 2 □ Cremation 3 □ Removal from State Output The state of the state of			4/10/20	006 F	alls C		
Balt	permit. Pages 1 and 2 should bu Department of Health and Menta Importent: If item 27 is marked any injury or other treumetic er once.		21 Signatur of uners pervice L ensee	Edi	ens Name and Address of Facility Vard Sagel Fun	neral I	Directi	.on		
		_	23a art1. Enter the disease, or complications that caused the		ZI KOCKVIII E	PIKE KO	20877111		0852	Approximate
	Physician		Immediate Cause (Final		scular Accide					Interval Between Onset and Death
	/Medical		disease or condition resulting in death) Due to (or as a con		Scular Accide	111				
	Examiner									
	₽ #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	sequence of):						
	and trans	Examiner	that initiated events							
8760,	cate be executed physician and the burial-transit		Due to (or as a con	sequence of);					I	
387	physicate s the	dical	d							
9 x	death certific e attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pre	egnancy				32d Day	of delive	
Вох	death atter	ciar	in the past 12 months? 1 Yes 2 No		Ectopic pregnancy Other (specify)			Mon		Day Year
o.	that the di ed by the detached	hys	9 ☐ Unknown 9 ☐ Unknown							
s, D	The law requires that the the has been signed by thoage 2 should be detache	by P	Part II. Other significant conditions contributing to death but not	resulting in the un	derlying cause given in Part I	I.	23e. Did toba	cco use contr	bute to th	e cause of death?
ğ	v require been sig should b	ed t					1 🗌 Yes	2 X No	3 ☐ Proba	ably 4 Unknown
000	aw requas been 2 should	Completed					24a. Was an	24b. W	ere autop	osy findings available
æ	The lavate has	E O					autopsy performe	d? d	eath?	npletion of cause of 2D No
Vital Record	ysicien: Th is certificate director, pag	Bec	25. Was case referred to medical examiner?		26. Place		heck only one)	XIII	_ 163	X 110
	S S in	2	Hospital:	2 ER/Outpatient	3□ DOA Other: 4□ Nu	ursing Home	5 Residen	ce 6 v Othe	r (Specify	Hospice
U		on;	27. Manner of Death 1 ▼Natural 5 □ Pending 28a. Date of Injury (Month, Day Yea.	r) 28b. Time of Injury	28c. Injury at Work?	28d.	. Describe how	injury occurre	d	поръсс
sio	r Attending er death. rector: Afte by the fune	catl	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2					
É		Certification;	4 Homicide determined 28e. Place of Injury - A building, etc. (Sp	it home, farm, stre ecify)	et, factory, office		Location (Stre City or Town,		r or Rural	Route Number,
	Hospitel 24 hours a Funerel I stely filled		29a. Certifier 1♥ Certifying Physician: To the best of my			<u> </u>				
	To the Hospitel or within 24 hours afte To the Funerel Discompletely filled in	edical	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my 21 Medical Examiner: On the basis of exam and manner stated.	ination and/or inv	occurred at the time, date an estigation, in my opinion, dea	nd place, and ath occurred a	due to the cau it the time, date	se(s) and mar and place, a	ner as sta nd due to	ated. the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier		29c. License number		290	I. Date signed	(Month, E	Pay, Year)
•	6		mo mo		D35635			April :	7, 20	06
	•		30. Name and address of person who completed cause of death (T T	WD 2005				
	Sta	6	Joseph Kaplan 6001 Muncaster 31. Date filed (Month, Day, Year) 2. Registrar's Si			ענאַ ענאַ))			
	Registr	-	APR 1 0 2006 2. Registrar's Signature							

Division of Vital Records, P.O. Box 68760, and strength of the law requires that the death certificate be executed after death.

The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and point in by the funeral director, page 2 should be detached for use as the burial-transit are burial-transit.

Physician

/Medical

Examiner

Funeral

Director

or 28e-f ehov

or Iteme 23a

Baltimore, Maryland 21215-0036

1 and 2 should be filed within Health and Mental Hygiene. em 27 ls marked other than

other traumatic event,

permit Pages 1 and 2::
Department of Health at Important: If item 27 is any in ury or other traugones.

Directo

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Completed

Be

Medical Certification; To Be Completed by Physician/Medical Examiner

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		ic pregnancy r (specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlyi	ng cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
ASC	UD		1 Yes 2 No 3 Probably 4 Unknown
PARI	iju sonjsvy		24a. Was an autopsy performed? 1 Yes 2 No 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical examiner?		26. Place of Death	(Check only one)
1 Yes 2 No	Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐	DOA Other: 4 Nursing Hom	ne 5 Residence 6 Other (Specify)
27. Manner of Death 1		8d. Describe how injury occurred	
3 Suicide 6 Could not 4 Homicide determine		ctory, office 2	8f. Location (Street and Number or Rural Route Number, City or Town, State)
	Physician: To the best of my knowledge, death occusiminer: On the basis of examination and/or investigation and manner stated.		nd due to the cause(s) and manner as stated. Id at the time, date and place, and due to the cause(s)
29b. Signature and title of certifier		29c. License number	29d. Date signed (Month, Day, Year)
•	J. P. She	D-21173	4/7/06

3450 QLD WASHINGTON RD. STE 203A WALDORF, MD 20602

State Registrar

18,0

within 24 hours after death To the Funeral Director: / completely filled in by the f

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NIRAN P. SHARMA MD

31. Date filed (Month,

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April **Physician** 14, 2006 FIGGS HENRIETTA ELIZABETH 7:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner White Hall Harford Sunshine Acres If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 3/23/1923 Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 ☐ M 2 💢 F Director 212-32-2133 83 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "naturel", or items 23s or 28s-f show the Medical Examiner Livist by notified at Funeral Director MD. Harford Fallston 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3455 Fallston Road 21047 United States death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or item any injury or other traumatic event, the Modical Experimentance. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No þ Specify: Specify. 3 XWidowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 Domestic Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Powell Flora James Lenora Grande Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James A. Figgs /Son 304 Plaza Court Aberdeen, Md. 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Lukes Cemetery 4/21/06 Hereford, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Jarrettsville, Maryland E.G. Kurtz & Son Funeral Home, P.A. Mockela 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Artery Disease **Physician** Coronary years /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? erebrovacular Accident 3 ☐ Probebly 4 ☐Unknown 1 Tyes ganella Sepsis etes Mellitus 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? Diebetes 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 100 within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 DNO 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner. On the basis or examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) April 14, 2006 D35012 30. Name and address of person why completed cause of death (Item 23a) (Type, Print) Bel Air, Md. 21004 LYNCH MS North Ave. J. Kevinl 31. Date filed (Month, Day, Year) 32. Fegistrar's Signature State Registrar

			1 - For Stata Registrar	State of Ma		partment of t e <i>rtificate of</i>		Mental Hygie	ene 1. No. 0 0 6	12910		
	ő.		1. Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death		
	Physici /Medio		EVERARD THERON	GRIM				ADD L	Day Year	2350 PM		
, a	Examir	er	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Dea	ith	4c. County of Death			
			WASHINGTON COUNTY				AGERSTOW		WASHI	NGTON		
	Funeral Director		5. Social Security Number 6. Set	M 2DE	(In yrs. last birthda OF Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Day, Y	(ear) 9. Birth	place (Stete or Foreign intry)		
			215-14-2574 " Sual Residence of Decedent		85 Yrs.			JAN. 7,	1921 M	ARYLAND		
	yland how		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits		
	e Ma	Director	MARYLAND WASHING	TON		SH	ARPSBURG	3		1 ☐ Yes 2X No		
	ith th	Dire	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Cou	intry?		
	ath w		17408 SHEPHERDSTOW				21782		U.S.	Α		
	ler de	Funerai		12. Was Decedent E Armed Forces?		. Was Decedent of h If Yes, specify Cub	Hispanic Origin? (: an, Mexican, Pu <i>e</i> i	Specify Yes or No- nto Rican, etc.)	14. Race - Ameri Black, White			
36	irs aff	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:	•	1 ☐ Yes 2X No	Specify:	Specify: LIUTTE				
21215-0036	within 72 hours after death with the Maryland ene. than 'naturet', or Items 23e or 28e-f show fa Madical Exactiner mast be confilled at	ted	15. Decedent's Edu	cation	16a. Dec	edent's Usual Occup	pation	16b. Kind of Business/Industry				
215	thin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5-	lite	re kind of work done DO NOT use retire	during most of wo d)	rorking				
	filed wi Hygien other th	Соп	12			INSPEC	TOR	AIRCRAFT MANUFACTURE				
pu	tal Hid off	Be	17. Father's Name (First, Middle, Last)					ım <i>e (First, Middle, M</i> a	iden Sumame)			
$\frac{8}{5}$	should ind Men ind Men ind Men	ဥ	JAMES H. GRIM					AY GIFFIN				
Maryland	C/ co = 0		19a. Informant's Name/Relationship (Ty) M. ELOISE GRIM/SPC					ural Route Number, City or Town, State, Zip Code) IKE, SHARPSBURG, MD 21782				
	1 and Health Iam 27 other to		20a. Method of Disposition	USE	20b. Place of Dist	osition /Name of			C. Location - City or T	21782		
altimore,	Pages nent of nt: If It iry or o		1 ⊠ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, cr	ematory or other pla	F		•			
፷			21. Signature of Funeral Service Licente	98		MANOR CEM 22. Name and Addre	1. 04/1	4/2006 SI	HARPSELTG,	MARYLAND		
ä	permit. Departr Importe any inj		I will Mille	w Paul M	I. Dean I	BAST FUNER	PAL HOME		National o, Marylan			
П			23a. Part T. Enter the disease, or complishock, or heart failure. List only on	cations that caused to	he death. Do not e	nter the mode of dyir	ng, such as cardia	ic or respiratory arrest	, real y lair	Approximate		
П	Physician		Immediate Cause (Final disease or condition	a carta		1-0	. 1.	7 -		Inferval Between Onset and Death		
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):	e caret	nya	relion		minule		
	Examiner		Sequentially liet conditions,		0		V					
	ed sit	jne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):							
	ai-trar	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequence of):							
68760	tificate be executed g physicien and as the burial-transit											
9	tificat ig phy as th	ledicai										
Box	death certifica e attending ph od for use as t	N/UE	Loo. Trad dodedont programt	3c. If yes, outcome o 1□Live birth 2		□Ectopic pregnancy			23d. Date of delive	ery		
	0 0 0	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at ti		Other (specify)			Month	Day Year		
0.	d by the etached	by Physician/M	9 Unknown									
Š,	The law requires that the the has been signed by the page 2 should be detached.	þ	Part II. Other significant conditions con	thouting to death but	not resulting in the	underlying cause giv	en in Part I.		co use confribute to the	_,		
Ö	w require been si should b	Completed	diabetes type	+				1 L Y # 8	2 No 3 Prot	pably 4 Unknown		
Records,	has l	mp	V					24a. Was an autopsy	prior to co	psy findings available mpletion of cause of		
		ပ္ပ	Or West and the second					performed 1 ☐ Yes 2 ☐		2□ No		
	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital:	t 2□ER/Outpatie	ont all pos Oth		ath Check only one				
ō	g Phy er this eral di	\vdash	27. Manner of eath	28a. Date of Injury	28b. Time	ALL DOA	4 Nursing F	dome 5 ☐ Residenc 28d. Describe how	e 6 □Other (Specifi	y)		
0	ath. r: Aft	atio	1 Natural 5 □ Pending 2 □ Accident investigation	(Month, Day	Year) Injury		k? Yes 2.∐No		. ,			
DIVISION	er de recto by tr	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur	y - At home, farm, s (Specify)	treet, factory, office		28f. Location (Stree City or Town, S	et and Number or Rura	il Route Number,		
3	ital o	Š										
	he Hospital or Attending Phin 24 hours after death. he Funeral Director: After th pletely filled in by the funeral	edical	29a. Certifier (Check only one) Certifying Phys	er. On the basis of e	xamination and/or ii	th occurred at the time	ne, date and place pinion, death occu	e, and due to the caus urred at the time, date	e(s) and manner as stand place, and due to	tated. the cause(s)		
	To the Hos within 24 h To the Fur completely	Mec	29b. Signature and title of certifier	and manner state	, u.	29c. License						
	- s + ó		and the state of t									
			Method D32518 4/12/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr Guedenet 21 Wyand Drive Keedysville Md 217									
4-	-5		Dr Guedenet	211	Dyand	Drive	Keed	Dysville	Md 217	156		
	Stat Registra	e	31. Date filed (Month, Day, Year) APR 13 20	32. Resistrar	-100-1		-31113					
	riegioni		for V	######################################	- 11.	158 N. C. C. C.						

			For State Registrar	State of Marylan	-	artment of rtificate of			jiene 0 0 E	12911
	Physici		1. Decedent's Name (First, Middle, Last)			Gree	76	2. Date of Dea Month		3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, give s The Johns Nookin)	& Nospital		Baltime	or Location of De	ath t	4c. County of [Death
	Funeral Director		5. Social Security Number 6. Sex 216 98 1228	w Vive	last birthday) 38 Yrs.	If Under 1 Yea Months Day:			9. 1967 W	Birthplace (State or Foreign Country) JASHINGTON, DC
	be filed within 72 hours after death with the Maryland ital Hygiene. Ital Hygiene do ther then "natural", or iteme 23a or 28a-f ehow event, the Medical Examinar must be notified at	Director	10a. State 10b. County MARYLAND PRINCE GE		y, Town or Lo ON HILI					10d. Inside City Limits XXYes 2☐No
	with the	Dire	10e. Street and Number 1805 BRIERFIELD RO	AD		10f. Zip Code	207/5	1	0g. Citizen of Wha	•
	death	Funerai		2. Was Decedent Ever in U Armed Forces?	.S. 13. \	Was Decedent of	20745 Hispanic Origin?	(Specify Yes or No- erto Rican, etc.)		American Indian,
3036	2 should be filed within 72 hours after death with the Maryla and Mental Hygiene and Mental Hygiene is marked other then "natural", or iteme 23a or 28a-f show sumatic event, it a Medical Examinar must be notified at	by	MXNever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes AXXNo If Yes, Give Year or Dates:		1 Yes XIX No		erto Hican, etc.)		Vhite, etc. BLACK
21215-0036	within 72 t ne. hen "natu nedica	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give life. l	DO NOT use retir	e during most of w ed)	rorking	16b. Kind of Busine	ŕ
9	Hygie other	Be Co	12 TH 17. Father's Name (First, Middle, Last)		PHYSIC	JAL THER	APIST AS 18. Mother's N	SISTANT ame (First, Middle, M		NCE HOSPITAL
ylan		To B	LAWRENCE GREENE				LAURA	MORROW		
Š∶	9 S N S		19a. Informant's Name/Relationship (Type LAURA GREENE / MOT	HER	1805	BRIERFI			City or Town, State	
Baitimore,	permit. Pages 1 en Department of Heal Important: if Item 2 any niury or other DDC#.		20a. Method of Disposition XX Burial 2 □ Cremation 3 □ Re	emoval from State	emetery, cren	sition (Name of natory or other pl	1		20c. Location - City	
att	partme portan y njur		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License				ERY │04/ ^{PSS of} ########	06/2006 AL HOME 01	ALEXANDI	
n	88 = 88		7. 11 a	ushll	4	308 SUI	TLAND RO	AD SUITLA	AND, MD 2	
	Physician /Medical		23a. Part1 Enter the disease, or complic shoot or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line. Due to (or as a consequence)				ac or respiratory arre	est,	Approximate Interval Between Onset and Death
E	Examiner			Brain art	uence of):	e and i	malfor	no trivo		78
	st s	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	uence of):			3201		720.3
Ď,	cate be executed physician and the burial-transit	I Examiner	that initiated events resulting in death) Last	Due to (or as a consequent	uence of):					
98/90	physics the t	edical	d.					_		
ROX	requires mat me deam certific een signed by the ettending p nould be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 √ s 2 □ No	Sc. If yes, outcome of pregna 125 ive birth 2 Fetal 4 Pregnant at time of de	Ideath 3□	Ectopic pregnan	су	75-	23d. Date of Month	Day Year
j.	at me de d by the e etached	Phys	9 ☐ Unknown	9□ Unknown					January	, 12 2006
cords,	w requires that been signed t should be det	þ	Part II. Dther significant conditions cont	Inbuting to death but not resi	ulting in the ur	nderlying cause g	iven in Part I.	23e. Did tob	1	e to the cause of death? Probably 4 Unknown
Hec	ate has b	Completed						24a. Was ar autops perform 1 ☐ Yes 2	y prior	
Vitai	rnysician: In	o Be	25. Was case referred to medical examiner? 1 □ Yes 25 No	ospital: 1 XInpatient 2 🗆	ER/Outpatien	3□ DOA O	M	eath Check only on		
	After fune	\vdash	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	4 🗆 Nursing	Home 5 Reside		ipecify)
=	9 € 57 .5	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stre	eet, factory, office)	28f. Location (Str City or Town	reet and Number or o, State)	Rural Route Number,
	within 24 hours a To the Funerei I completely filled	edical (29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examin	ician: To the best of my kno er: On the basis of examinal and manner stated.	wledge, death tion and/or inv	occurred at the restigation, in my	time, date and plac opinion, death oc	ce, and due to the ca curred at the time, da	ause(s) and manner ate and place, and o	as stated. due to the cause(s)
	within 2 To the	Ž	29b. Signature and title of certifier	1			ise number	i	9d. Date signed (M	
, l	(4)		30. Name and address of pers who con	Mu MD	192a) (T	RE	2-001	1	April 4	,2006
`	200		Wesley Hsu	600 N. Wo	1 /c	Street	Baltin	ore MD	2128	7
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 7 2006	32. Registrar's Signa	ture					

			1 - For State Registrar	State of Ma	ryland /	-	artmen tificate			and M	lental Hy	giene Reg. No.	006	£ 6.49	
	Physici	-	Decedent's Name (First, Middle,	Last)							2. Date of De	ath Day	Year	3. Time of Deal	th
	/Medi		Rebecc		NN						04	00	66	1215	М
1	Examir	ier	4a. Facility Name (If not institution,				4b. City,	Town, or	Location of	of Death		4c. (County of Death	1	
			Anne Arundel Me 5. Social Security Number 6		(In yrs. last b	idhdayl	Anna If Under		S If Under:	24 Hrs	0. Date of Bir		ne Aruno		
	Funeral Director		223-22-2312	1 M 2 F	(III yrs. Iasi D	Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Da		9. Birth Con	nplace (State or For untry)	aign
			Usual Residence of Decedent								July 18	, 192	4 111	ginia	
	ırylan t how	_	10a. State 10b. County		10c. City, To	wn or Lo	cation							10d. Inside City Lin	
	Ba-f s	cto	Maryland Anne Ar	unde1	Annap	olis		_						1 X Yes 2 □	No
	vith th	Dire	10e. Street and Number				10f. Zip					10g. Citiz	en of What Cou	untry?	
	eath v	era	35 Milkshake La	12. Was Decedent Ev	or in II C	12.1	_	1403	i- Ori	===2 (0==	eif . Was as Ma	U.S	A. Race - Amer	ina India	
10	fter d	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?) HI (0.5.				n, Mexican	gin / (Spe i, Puerto i	cify Yes or No Rican, etc.)	'	Black, White		
036	urs a	by	3 ₩Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1	1 ☐ Yes 2	2⊠ No	Specify:				Specify: Whi	te	
20	be filed within 72 hours after death with the Maryland that Hygiene. Ided other then "naturel", or Items 23e or 28e-1 show event, the Medical Examinar must be notified at	Completed	15. Decedent's (Specify only highest		16	a. Deced	ient's Usua	l Occupa	tion	t of worki	ng.		d of Business/I		
2	within ene.	npie	Elementary/Secondary (0-12)	College (1-4or 5+))	life. L	kind of wor DO NOT us	e retired)	uning mosi	OI WOIKI	<i>'</i> 9				
2	filed w Hygier Ither th		12	-41	Н	lomen	naker						Home		
anc	ould be fi Mental H arked ot atic ever	Be	17. Father's Name (First, Middle, La	SI)							(First, Middle	, Maiden S	Sumame)		
N	should be ind Menta imarked imatic ev	မ	George Russell 19a. Informant's Name/Relationship	(Type Print)	10	h Mailin	a Addross	/Street a		-	gason	or City or	Town, State, Zi	in Code)	
Maryland 21215-0036	2 8 9		Brenda C. Alexan												
ē,	t Health tem 27 other tre		20a. Method of Disposition	1	20b. Place	of Dispos	sition (Nam	ne of			ate		and 210 cation - City or T		
E O	0 0		1 A Burial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spe		Fort	-	natory`or of 1n Cer		. 1	4/5/	2006	Bron	twood	Maryland	
Baltimore,	permit. Pag Department Importent: I eny injury o		21. Signature of Funeral Service 1		,							uner	al Home	. P.A.	-
m	89 = 8		+allitie	11 ay									11e, MD		
г			23a Pan 1. Enter the disease, or co shock, or heart failure. List or	mplications that caused the	ne death. Do	not ente	er the mode	of dying	, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease r condition	Raid	wec	tyr	1/6	nic	a					Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a		_	1								
		<u>.</u>	Sequentially list conditions,	b. Due to (or as a	CONSEGUENCE										
	nsit	Examiner	any, leading to immediate cause. Enter Underlying Cause (Disease or injury	333 10 (5) 25 2	oonooqoonoo	3 31).									
Ć,	exection and ial-tra	Exa	that initiated events resulting in death) Last	Due to (or as a	consequence	e of):							-		
8760,	cate be executed obysician and the burial-transit			d											
9	rtifica ng ph	Physician/Medical	IF FEMALE:	CONTROL MANAGEMENT											
Вох	death certific e attending p d for use as 1	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2	Fetal deat	h 3 🗆	Ectopic pre	gnancy				23	3d. Date of deliver Month	very Day Year	
0	0 0	ysic	1 Yes 2 No	4⊡Pregnant at tii 9⊡ Unknown	me of death	5 🗀	Other (spe	ecify)					World	Day Toai	
٥.	requires that the de een signed by the a nould be detached t		Part II. Other significant conditions	contributing to death but	not resulting	in the un	derlying ca	use aive	n in Part I.		23e, Did t	obacco us	e contribute to	the cause of death?	,
ds,	90	d by	·	Ü			, ,	,			10,	Yes 2□	No 3□Pro	bably La Unkno	own
Ö	> 0 5	iete									24a. Was	an	24h Were aut	opsy findings availa	able .
Re	9 L 0	ompieted		· - · · · · · · · · · · · · · · · · · ·							autop perfo	osy rmed?	prior to co death?	ompletion of cause	of
Vital Records,	sicien: Th certificate irector, pag	o C	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes	al No	1 ∐ Yes	2 No	
<u> </u>	NS SI	To B	examiner? 1 Tyes 2 No	Hospital:	2 ER/0	utpatien	3 □ DO.	A Othe					☐Other (Speci	ify)	
n of			27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day)		Time of Injury	28	Bc. Injury Work		-	8d. Describe I				
Sio	Attending r death. ector; After by the fune	catio	2 Accident investigat				М		es 2□N	No					
Division	or Attendater deatl	Certification;	3 Suicide 6 Could not 4 Homicide determine			arm, stre	eet, factory,	, office		2	8f. Location (S City or Tov	Street and vn, State)	Number or Aur	al Route Number,	
	Hospitel 24 hours a Funeral f		29a. Certifier Al Certifying	Physician: To the heat of	Vaguelada	no doeth		A Ab - Ai		1 -1					
	24 hc Fun etely	edical		Physician: To the best of aminer: On the basis of e and manner state	xamination a	nd/or inv	estigation,	in my opi	inion, deat	h occurre	d at the time,	date and p	olace, and due t	stated. to the cause(s)	
	To the Hospitel or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	Me	29b. Signature and title of certifier				29c.	License	number			29d. Date	signed (Month,	Day, Year)	
	> - 0		EN A CU	SKA				DS:	70°Z	8		4/	266		
0	(2)		30. Name and address of person wh		th (Item 23a)	(Туре, Г	Print)					- /	1		
1	(3)	=	Aditya Chopra,			venu	ie, #2	231.	Anna	polis	s, Mary	land	21401		
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature															
at Date Had Afrails Con Van A															

`			1 - For State Registrar	State of Ma	aryland / De	oartment o		nd Mental	Hygien Reg. N	0007		2913
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of	f Death	NA NA NA NA	ear	3. Time of Death
	/Medic	cal	Horace Gerber 4a. Facility Name (If not institution, give s	street and number)		4b. City. Tow	n, or Location of			2006 c. County of		8:10 P M
	Funeral Director		Washington Advent 5. Social Security Number 6. Sex 089-05-9650		ital e (In yrs. last birthda 87 Yrs.				f Birth	Mont	tgome	ce (State or Foreign
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location		July	2.75 1	. 710 1		f. Inside City Limits
	the Maryla 28a-f eho	Director	Maryland Hyattsv	ville		George			10g C	itizen of Wha		1 ☐ Yes 2 ☐ XNo
	th with		6637 23rd Ave			207				ISA	it Country	
5-0036	be filed within 72 hours after death with the Maryland nat Hygiene. od other than "naturel", or items 23s or 28s-f ehow event, the Modical Examiner must be notified at	by Funeral		12. Was Decedent Armed Forces? 1 Yes 24 I If Yes, Give Year or Dates:			of Hispanic Origi Juban, Mexican,	in? (Specify Yes o Puerto Rican, etc.		14. Race -	White, etc	Indian, c.
21215-0	within 72 ho liene. r than "natu	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5	+) (Gi	edent's Usual Oc re kind of work do DO NOT use re Salesman	ne durina most i	of working		Kind of Busin	ess/Indus	
Maryland 2	m -= 0 =	To Be C	17. Father's Name (First, Middle, Last) Robert B. Gerber				Julia	s Name (First, Mic	ddle, Maidei	n Sumame)		
	1 and Health Bm 27 ther t		19a. Informant's Name/Relationship (Type Norman Gerber/Son 20a. Method of Disposition	•	66.	37 23rd .	Ave, Hya	or Rural Route No attsville Date	, MD			
Baltimore,	permit. Pages Department of I importent: if it any injury or or		1 Maurial 2 □ Cremation 3 □ R. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License		King Da		rial ¢ro	ins April Hines-Ri	_			Church V
	2072 # 91		23a. Part1. Enter the disease, or complic	cations that caused						er Spi		MD 20904
	Physician /Medical Examiner		shock, or heart failure. (ist only on Immediate Cause (Final disease or condition resulting in death)	Rect	a consequence of):	lip	\mathcal{T}	sen	e		In	nterval Between Inset and Death
8/60,	cate be executed obysicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, heading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a consequence of).							
O. Box 68	that the death certificate led by the attending phy: detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 ☐ Fetal death 3	□Ectopic pregna □ Other (specify,				23d. Date of Month	delivery Da	ay Year
rds, P	sign d be	by	Part II. Other significant conditions con	-	it not resulting in the	underlying cause	given in Part I.		id tobacco	_		cause of death?
al Hecord	The law ale has b page 2 s	Completed						24a. V a p 1 🗆 Ye	utopsy erformed?	prior	to compl h?	v findings available letion of cause of □ No
sion of Vital	ding Phys	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 November 1 Note 1 No	ospital: 1 23 Inpatiel 28a. Date of Injur (Month, Day		of 28c. Ir	Other: 4 🗆 Nurs		esidence	6 □Other (a	Specify)	
DIVIS	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	ry - At home, farm, s . (Specify)	treet, factory, offic	ce	28f. Locatio City or	n (Street ar Town, State	nd Number o e)	r Rural Ro	oute Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edicai	29a. Certifier 1 ☑ Certifying Phys (Check only one) 2 ☐ Medical Examin	ician: To the best of ar: On the basis of and manner sta	examination and/or i	th occurred at the nvestigation, in m	time, date and y opinion, death	place, and due to occurred at the tir	the cause(s ne, date an) and manne d place, and	r as state due to the	d. e cause(s)
	To T within	×	29b. Signature and tiple of certifier	05	igl		onse number 9 45		29d. Da	te signed (M	onth, Day	r, Year)
			39. Name and ad ress of person who cor	LLAK		(April)	PINDERZ	SINGH, 7	50	Lie		7D Ze 26
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 1 2	32. Pagistra	r's Signature	perter						

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 9, Day 2006 Year **Physician** William GORDON 9:05 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Hospital Silver Spring | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Property | 1925 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ₹M 2 ☐ F Pennsylvania 194-18-4754 80 Director Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show eny injury or other treumatic event, Ite Medical Exprine treat by rectlined at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Maryland Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20815 2611 East West Highway United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Tyes 2 No WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: white ð 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pharmacist Pharmacy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pearl Kravitz Benjamin Gordon 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Charry Chase, MD 20815 19a. Informant's Name/Relationship (Type, Print) Bernice Gordon, Wife 2611 East West Hwy., Chevy Chase, MD Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Lebanon Cemetery 04/11/06 Adelphi, MD 4 Donation 5 Other (Specify) 21. Signature of Fure al Service Licensee Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, 20012 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Pulmonary Embolus /Medical Due to (or as a consequence of) Examiner Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ettending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown certificate has been signed rector, page 2 should be def Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ∑ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2∏No To the Hospital or Attending Physician: 25. Was case referred to medical director Be 26. Place of Death (Check only one, Hospital: 1 | Inpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Yeer) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation Diractor: / 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide ā within 24 hours ? To the Funeral 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) myon D 62175 8+1 30. Name and address of on who completed cause of d Item 23a) (Type, Print) 1500 Glen Road, Silver Spring, MD 20910 Sangeeta Gupta, M.D Ferest 31. Date filed (Month 32 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Physician MARZETTA 4:59P L. GREEN April /Medical 2006 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Southern Maryland Hospital Clinton If Under 1 Year | If I Prince George If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) Funeral Months Days 1 M 2 TF Director 46 Wash, 577-80-4303 Nov.1,1958 DC Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits if item 27 is marked other then "netural", or items 23s or 28s-1 ehow or other traumatic event, tre Medical Examinst must be notified at MD Prince George Director 1 ☐Xes 2 ☐ No Forrestville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6019 Parkland Ct #102 20747 Funeral U.S.A 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "netural, or Item 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: ģ Specify: Black 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Assistant Administrative 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George W. Gaston Doris Cowherd ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20747 19a. Informant's Name/Relationship (Type, Print) Sharde Green- Daughter 6019 Parkland Ct #102 Forrestville, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cem 4/12/06 Clinton, MD 22. Name and Address of Facility Snowden Funeral Home, PA 21. Signature of Funeral Service Licensee eny in 246 N. Washington St Rockville, Doll MD20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) nbstructive Privaician hronic /Medical Examiner monn Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine Acidosis -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and attending physician a for use as the burialmy Fibrotic P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death | Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 2 ER/Outpatient 3□ DOA After the 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. M 1 Yes 2 No 2 Accident the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 □ Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide pelli 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OPEJANMI MI) sann doess of person who completed cause of death (Item 23a) (Type, Print) Obafemi Opesanmi, MD 7503 Surratts Road Clinton, MD 20735 31. Date filed (Month, Day, Year) State 11 2006 Registrar

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			State of Maryland / Department / Department / Department	ent of Health and M eate of Death			1291/
	9		Registrar 1. Decedent's Name (First, Middle, Last)	ale or Dealir	2. Date of Death	. No.	3. Time of Death
П	Physici		Terrell L. Haigler		April	$\overset{\text{Day}}{1} \overset{\text{Year}}{2006}$	0300 M
	/Medio ≏Examin			City, Town, or Location of Death		4c. County of Death	0300
	LAGITIT		3603 Stewart Road	Forestville		Prince Geo	orge's
	Funeral		Month	nder 1 Year If Under 24 Hrs. ths Days Hours Min.	8. Date of Birth (Month, Day, Y	9. Birthp	olace (State or Foreign htry) h Carolina
и	Director		248-49-0506 31 Yrs.		Dec. 23,	1974 Sout	h''Carolina
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits
	Mary -f sh	to	DC	Washingt	on		1 XYes 2 No
	r 28s	Director	10e. Street and Number 10f.	. Zip Code		. Citizen of What Cour	ntry?
	th wit		920 Eastern Ave., N.E.	20019		United	States
	ems ems	iner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was De Armed Forces? 13. Was De If Yes, s	ecedent of Hispanic Origin? (Spe specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	or it	by Funeral	1 Never Married 2 Married 1 Yes 2 No	s 2 No Specify:			Black
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene ther than "natural; or items 23e or 28e-f show ent, it a Mudical Exacular must be rediffed at	ed b	3 Widowed 4 X Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's U	Isual Occupation	16	b. Kind of Business/In	dueta
Ċ	n ne	Completed	(Specify only highest grade completed) (Give kind of	f work done during most of worki T use retired)	ing	D. Killa of Dasillessylli	uustiy
212	d with	E	Elementary/Secondary (0·12) College (1·4or 5+) 12th Ca	ar Detailer		Private	e
		ВеС	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma		
yla	2 should be filed within 72 hours after death with the Marylan and Manhal Hygene. Is marked other than "natural, or items 23e or 28e-f show sumatic event, it a Medical Exaction man be rediffed at	To	Stanley Haigler		Deborah	Thomas	
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a) -	t and fealth sm 27 ther t		Deborah Haig1er/Mother 920 F	Eastern Ave., N	E. Wash	DC 2001	g num State
ğ	ages nt of I :: If Its		1 X Burial 2 Cremation 3 Removal from State	or other place) n Cemetery 4/8/			,
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			23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the n shock, of heart failure. List only one cause on each line.	mode of dying, such as cardiac o	or respiratory arrest	,	Approximate Interval Between
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Jr.	/Medical		resulting in death) Due to (or as a consequence of):				
	Examiner		Sequentially list conditions, b.				
	ed sit	nine	if any, leading to immediate cause. Enter Underlying Cause, Disease or injury				
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
_	m 9 m	cal	d				
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Box	th cer tendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic	ic pregnancy		23d. Date of delive	
O. E.	e dea the at ned fo	sici	in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown			Month	Day Year
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cor	w require been sig should b	Completed			24a. Was an		psy findings available
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<u>ra</u>	Physician: The la r this certificate has ral director, page 2	4	25. Was case referred to medical	26. Place of Death	(Check only one)	No 1 TYes	2LJ No
₹	ysici iis cer direc	To B	examiner? 1 ☑ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐	l Out		e 6 🔀 Other (Specifi	y Scene
0	ng Ph fter th neral		27. Manner of Death 28a. Date of Injury 28b. Time of Injury Injury 28b. Time of Injury 28b. Time Injury 2b. Time Injury 2b. T		28d. Describe how	injury occurred	Decire
<u>0</u>	Attending Physician: If death. ector: After this certifict by the funeral director.	catic	2 Accident investigation 3 Suicide 6 Could not be	1011 -011	sugget	Short	
Division of	or Att	Certification:	4 Homicide determined 286. Place of Injury - At nome, farm, street, fact building, etc. (Specify)		28f. Location (Stree City or Town, S	et and Number or Rura State) 3 6 03 5 H	I Route Number,
	pital purs a erel (fording Front yanel of Chu 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurr		Evestville,	Many land	20742
	24 h 24 h Fun etely	Medical	(Check only one) Medical Examiner: On the basis of examination and/or investigat and manner stated.	tion, in my opinion, death occurr	ed at the time, date	and place, and due to	the cause(s)
	To the Hospital or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer.	Me	29b. Signature and title of certifier	29c. License number	29d	Date signed (Month,	Dey, Year)
	^		Theodolf link	OCME		April, 1,	2006
1	42		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				
	~~			11 Penn Street	Baltimo	re, Maryla	nd 21201
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signatur APR 1 0 2006				
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	/Medio Examir		4a. Facility Name (If not institution, gir	re street and number)		4b. City,	Town, or	Location o	f Death	71/28	4c. County of I	
	SE T. A		Washington Count						stown				ington
À	Funeral Director			Sex 7. A 1 □ M 21X F	ge (In yrs. last bii 70	Yrs.	If Under Months	Days	If Under a	Min.	8. Date of Birth (Month, Day April 5	, 1936 1	Birthplace (State or Foreign Country) Maryland
	/land		10a. State 10b. County		10c. City, Tow	n or Lo	cation						10d. Inside City Limits
	Man Be-fah	io	Maryland Washin	gton	Hag	erst	cown						1 ☐ Yes 2 🕅 No
	or 28	Director	10e. Street and Number			_	10f. Zip					10g. Citizen of Wha	t Country?
	ath w	a l	13915 Paradise			1			742			USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Itam 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic avant, I'm Medical Examinar must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 Tes 2 Street If Yes, Give Year or Dates:	? [No		Vas Deced Yes, spec		spanic Origin, Mexican Specify:	gin? (Spe i, Puerto i	cify Yes or No- Rican, etc.)	14. Hace - , Black, \	American Indian, White, etc. white
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Mar	12 sh h and 7 ie m raum		19a. Informant's Name/Relationship				_					r, City or Town, Sta	
	1 and Healtl am 27 ther t		Thomas Hall - hu 20a. Method of Disposition	Spand	20b. Place o	f Dispos	sition (Nam	ne of	T		ate	20c. Location - City	, Md. 21742
Baltimore,	ages nt of t: if it		1 Burial 2 Cremation 3		cemete	ry, cren	own Ci	ther place					vn, Maryland
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	Physician /Medical Examiner	ılner	23a. Pant1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a	s a consequence	of):	1	Ar	tery	1000	Disea iny		Approximate Interval Between Onset and Death
Box 68760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and rall director, page 2 should be detached for use as the burial-transit	by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d23c. If yes, outcom	s a consequence of pregnancy End death	of):	Ectopic pro	egnancy				23d. Date o	
P.O.	the d y the iched	yslo	1 Yes 2 No 9 Unknown	9□ Unknown	at time of death	5	Other (Spe	SCIIY/					
	quires that n signed b uld be deta	d by Pt	Part II. Other significant conditions	contributing to death	but not resulting i	n the un	nderlying ca	ause give	n in Part I.				te to the cause of death? Probably 4 Minknown
Division of Vital Records,	2 3 8	Completed		· · · · · · · · · · · · · · · · · · ·		-					24a. Was a autop: perfor	med? prior dear	e autopsy findings available r to completion of cause of th? Yes 2 □ No
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)ivisio	or Attending after death. Director: After in by the tune	Certification;	2 Accident investigation 3 Suicide 6 Could not I 4 Homicide determined	28e. Place of Ir	njury - At home, fa etc. (Specify)	arm, stre	M eet, factory		/es 2 □ l		28f. Location (S City or Tow		or Rural Route Number,
_	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the tuneral director, page	edical Ce	29a. Certifier 1 ☐ Certifying P (Check only one) 2 ☐ Medical Exa	hysician: To the bes miner: On the basis and manner s	of examination ar	e, death	occurred a restigation,	at the tim in my op	e, date and inion, deat	d place, a	and due to the co	ause(s) and manne late and place, and	er as stated. due to the cause(s)
	omple	Me	29b. Signature and title of certifier				29c		number	,	2	9d. Date signed (A	fonth, Day, Year)
			fand	muched				DO	603	396		04/10/	06
51	4-5		30. Name and address of person who	completed cause of		(Туре, І	Print) 1	12	6 C	pal	stown	MD	21740
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			For State Registrar	State of	Marylar		artment of rtificate c				iene	105	12919
	Physici /Media		Decedent's Name (First, Middle, Land ROSIE LEE HALL	ast)				74		2. Date of Dea Month APRIL	Day	Year 2006	3. Time of Death 1:34A M
	Examir		4a. Facility Name (If not institution, gir PRINCE GEORGES		11	R	4b. City, Town	n, or Location	of Death			county of Death	EORGES
	Funeral Director		568 42 9148	Sex 1□M XXXF 7.		last birthday) 75 Yrs.	If Under 1 Ye Months Da		Min.	8. Date of Birth (Month, Day UNE 17	, Year)	Cour	
	Maryland -f show	tor	Usuel Residence of Decedent 10a. State 10b. County MD PRINCE (GEORGES		ty, Town or Lo						1	IOd. Inside City Limits XX Yes 2 □ No
	or 28a	Director	10e. Street and Number		101		10f. Zip Cod					on of What Cour	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 Is marked other than "naturel", or Items 23e or 28e-f show other treumatic event, If a Maclical Examirar must be neithed at	by Funerai	6605 EVANSTON S 11. Marital Status 1 Never Married XXX Married 3 Widowed 4 Divorced	12. Was Deceder Armed Force 1 Yes & If Yes, Give Year or Date	es? XNo		Was Decedent of Yes, specify C	of Hispanic Or Juban, Mexica	rī, Puerto F	cify Yes or No-	14	ED STAT: Race - Americ Black, White, Specify: BLA	can Indian, etc.
Maryland 21215-0036	within 72 hou ene. than "nature he Medical E	Completed I	15. Decedent's Elementary/Secondary (0-12)	ducation		(Give	dent's Usual Oc kind of work do DO NOT use rei	ne durina mos	st of workin	g		of Business/In	dustry
yland 2	2 should be filed and Mental Hygi Is marked other eumatic event, II	To Be Co	17. Father's Name (First, Middle, Las HOWARD LEWIS	t)				ALI	BERTA	(First, Middle,	Maiden Si Y	итате)	
Mar	and 2 sh ealth and n 27 is m		19a. Informant's Name/Relationship THEARTHUR HALL)		ng Address <i>(Stre</i> EVANST(-	Town, State, Zip E, MD 20	
altimore,	permit. Pages 1 and 2 Department of Health of Important: If Item 27 I any injury or other tre		20a. Method of Disposition XX Burial 2 Cremation 3 (4 Donation 5 Other (Special Control of Contr		ate (cemetery, crer	sition (Name of natory or other i	olace)		/2006	20c. Loca	ation - City or To	own, State
Balti	permit. Departri Importa any inju		21. Signature of Funeral Service Lice	cull	Q	M22		dress of Facil	ERAL I	HOME OF	MAR	YLAND, II	NC.
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Division of Vital Records,	Attending Physicien: Thir death. ector: Atter this certificate by the funeral director, pag	ion; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Magner of Seath 1 Natural 5 Pending	28a. Pate of Month,		ER/Outpatier 28b. Time of Injury	28c. lr		ursing Hom	(Check only of the 5 Residence Resid	ence 6 (Other (Specif	y)
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	To the Hospitel or within 24 hours after to the Funeral Dir completely filled in	Medical C	29a. Certifier Certifying P	hysician: To the base and manne	is of examina	owledge, death ation and/or in	n occurred at the vestigation, in m	e time, date a ly opinion, de	nd place, a ath occurre	nd due to the o	ause(s) a late and p	nd manner as s	tated. o the cause(s)
	To the To that complete	Σ	29b. Signature and title of certifier	A CONTRACTOR OF THE PARTY OF TH			29c. Lic	ense number	3/8	2	29d. Date	signed (Month,	Day, Year)
	(10		30. Name and address of person who	S. MD	300	1 HOSPI	Print) TAL DR			Y, MD	<i>7/</i> 20784	100	2
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

use as the burial-transit Records, P.O. Box 68760, the attending physicien page 2 should be detached for Division of Vital Hospitel or Attending Physician: 24 hours after death. Funeral Director: After this certifice 24 hours a

2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Vasi **Physician** 10:38 AM William Thomas Hall April 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. 1 💢 M 2 🗆 F Months Davs Hours Yrs Director 1932 North Carolina 29, 237-46-1365 74 Mar. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f ehow the Medical Examiner must be notified at 1 XYes 2 No Directo Maryland | Prince George's Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ or Iteme 23a 2211 Gaylord Drive 20746 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No δ If Yes, Give Year or Dates: Yes Give Specify: Specify: B1ack 3 XWidowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 Electrical Inspector Government permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 le marked other eny injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Odie Hall, Sr. Emma Fleming ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1016 Philip Powers Drive, Laurel, Laurie Hall/Daughter MD 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 20c. Location - City or Town. State 1

Burial 2 □ Cremation 3 □ Removal from State Harmony Memorial Park 4/8/2006 4 ☐ Donation 5 ☐ Other (Specify) Landover, MD 21. Signature of Funeral Service Licensee. 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Acute Congestive Heart Failure /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Myocardial Infarction
Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 X No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1X Inpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) ္ 1 ☐ Yes 2 🂢 No 2 ER/Outpatient 3□ DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Medical 29a. Certifier 1 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Nedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Within 2 29b. Signature and title of certi 29c. License number 29d. Date signed (Month, Day, Year) D41624 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patrick Murray, M.D. 1500 Forest Glen Road, Silver Spring, MD 20910 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

APR 0 6 2006

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Physician Month Day РΜ ELEANOR HENSHAW 2006 HIATT 5 12:30 <u>April</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner FRIENDS NURSING HOME SANDY SPRING MONTGOMERY 8. Date of Birth (Month, Day, Year) JULY 6,1930 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F 368 30 8204 Yrs. Director MICHÍGAN Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Iteme 23a or 28a-f ehow the Mudical Examiner must be notified at MD. **MONTGOMERY** SANDY SPRING **Funeral Director** 1 ☐ Yes 2 PNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17300 QUAKER LANE 20860 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Btack, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No þ Specify: WHITE 3 ☐ Widowed 4 M Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 BOOK EDITOR TEXT BOOK PUBLISHING permit. Pages 1 and 2 should be file Deperment of Health and Mental Hy Important: If flem 27 is marked other son injury or other treumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BENJAMIN FRANKLIN HENSHAW RUTH BUCK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAMUEL D. HIATT. 545 VISTA TRAIL COURT, PALM HARBOR, FLORIDA 34683 SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metropolitan Crematory 4/08/06 4 ☐ Donation 5 ☐ Other (Specify) ALEXANDRIA, VA. 21. Signature of Funeral Serv. Liven ve 22. Name and Address of Facility MURIEL H. BARBER FUNERAL HOME M-00470 P.O. BOX 5038- LAYTONSVILLE, 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MYOGARDIA MINUTES /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. attending physicien for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Ø No Month Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ PRESSURE HYPROCEPITALUS 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No : After this certifice e funeral director, f Be (25. Was case referred to medical 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 1 ☐ Yes 2 Mo 28c. Injury at Work? Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 Yes 2 No investigation 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Dev. Year) 2006 erson who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

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Registrar

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Ex	xamin	er	4a. Fecility Name (If not institution, give	street and numb	er)		4b. City,	Town, or	Location of Dea	ath		4c. County	of Death		
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	neral ector		3/0-30-0200	x ∃M 2[X]F	Age (In yrs. Ia	st birthday) Yrs.	If Under Months	Days	If Under 24 Hr Hours Mir		3irth 1944 	ar)	9. Birthp Walsh	ington,	or Foreig , DC
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parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hygiene.	varninar.m	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. Was Decede Armed Force 1 Tes 2 If Yes, Give Year or Date	es? ⊠ No	'	Was Deced if Yes, spec 1 ☐ Yes	ify Cuba	spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or f into Rican, etc.)	No-		k, White,	can Indian, etc. hite	
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Physic /Med Exam Exam But All Physician and	dical niner	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or Due to (or c.	as a consequence as a c	ence of):	78S/	Rc	dive	- lvng	7 1)	l Sla	Se	linler	10 VA
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To the Hospitel or Attending Physician: The law requir Within 24 hours after death. To the Funeral Director, After this certificate has been si	uneral dire	္	1 Yes 2 100 27. Manner of Death 1 1 Natural 5 Pending	28a. Date of		R/Outpatien 28b. Time of Injury	2	8c. Injury Work	at ?	Home 5 Re				y)	
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(12)	/	İ	30. Name and address of person who co	mpleted cause	of death (Item	23a) (Type	Print)	Ara	stoo Yazd	lahi MD	H-5	ar,	1)	06	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month p_{M} Josephine C. Hines 1:05 April 03,2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😡 F 231-36-1100 Jan 21,1926 North Director Carol Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or Items 23a or 28e-f show the Medical Exempler must be notified at Forestville PGMd 1 Yes 2 No Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 2506 Newglen Ave 20747 USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify: þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Industry Practical Nurse 10th permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked other any injury or other treumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Albert Chrisp Ida McBroom 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry W. Lester(Son) 6731 Darby Rd Landover, Maryland 20784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 04-07-06 Clinton Md. Resurrection Cem 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Thelly Tyrone J. Young 719 Kennedy St. NW 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ongeshire Immediate Cause (Final disease or condition resulting in death) neart **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ed by the attending physicien and detached for use as the burial-transit to the Hospital or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) Yes 9 Unknown Part II. Dither significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ ascular 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 ☐ Yes 2 ☐ No the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient Certification: To 3☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours e To the Funerel [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifiet 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) SOLCONICWO, MD 00055314 04.04.2006 30, Name and address of person who completed cause of death (Item 23a) (Type, Print)
SYLVES TER OKONICWO, 6192 OXO9 HTLL RD, 507, OXON IHILL, MO 20745 31. Date filed (Month, Day, Year) State

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Registrar

		State of Maryland / Department of Health a 1- State Registrar Certificate of Death		(1000	12924
	(8 ³⁾	Decedent's Name (First, Middle, Last)	2.1	Reg. Date of Death		3. Time of Death
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15, P.O. I res that the de signed by the sibe detached it be detac	Physiclan/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown				
s that some be detailed by	by Pt	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I	1.	23e. Did tobac	co use contribu	ite to the cause of death?
Cords * require: been sig				1 🗆 Yes	2 No 3	☐ Probably 4 ☐ Unknown
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Of \Physical directions	5			5 Residence		(Specify)
Division of Vital Records, to Attending Physician: The law requires the after death. Director: After this certificete has been signed in by the tuneral director, page 2 should be continued.	to	27. Manner of Death 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of Injury Work? 1 □ Yes 2 □	1	Describe now i	injury occurred	
VISIO Attendi r death. ector: A	flca	3 Suicide 6 Could not be	28f.	Location (Stree	t and Number o	or Rural Route Number,
Div lal or s afte el Dire	Certification;	4 ☐ Homicide determined building, etc. (Specify)		City or Town, S	tate)	
Hospii 4 hour Funer ely filli		29a. Certifier (Check only Medical Exeminer: On the basis of examination and/or investigation, in my opinion, dea	and place, and a	due to the caus t the time, date	e(s) and manne and place, and	er as stated. due to the cause(s)
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical	one) and manner stated. 29b. Signature and title of certifier 29c. License number		29d.	Date signed (A	Month, Day, Year)
F 5 F 8		► 6/0M/JHH NO 04760	3	3	13110	G
0 (5)		30. Name an address of person pleted cause of death (Item 23a) (Type, Print)	7/0-	11 1	1	1110 0-11
W.		William DW30yce, MO 4000 MHellemille 12	11 132	16 15	ava,	W 30/16
S Regis	tate trar	APR 0 6 2006 Steele & Signature				
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			1 - For State Registrar	State of M	laryland		artment of I rtificate of		and Mental H	Reg. N	000	and the second s	292	25
	Physici		1. Decedent's Name (First, Middle Mary Lorett						2. Date of I Month April	0	ay Y 2006	'ear	3. Time of 7 • 35	
	/Medic Examin		4a. Facility Name (If not institution)		4b. City, Town, o	r Location o			c. County of	Death	-/	
L			19112 Sandy F		// /-	- A & (-4b -/)	Knoxvil		24 Hrs. 8. Date of E		<i>l</i> ashing		(0)	
П	Funeral Director		5. Social Security Number 219-26-4526	6. Sex 7. A 1 M 2	ge (In yrs. Ia. 80	Yrs.	Months Days	Hours	Min. (Month, I	<i>Јау, Үөа</i>		Counti Mary	ace (State o ry) Land)r roreigii
	pu *		Usual Residence of Decedent 10a. State 10b. County			Town or Lo	cation						d. Inside Ci	lity Limits
	ath with the Marylar 23s or 28e-f show ust be notified at	ō	MD Washir			oxvill								21 No
	h the	Funeral Directo	10e. Street and Number	ig con	TOTAL	JAVIII	10f. Zip Code			10g. 0	Citizen of Wh	at Count	ry?	
	ath wit	ai	19112 Sandy H				21758			<u> </u>		SA		
	er dez Items	nue	11. Marital Status 1 □ Never Married 2 □ Marr	12. Was Deceden Armed Forces	?	i. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Orig an, Mexican	gin? (Specify Yes or I , Puerto Rican, etc.)	No-	14. Race - Black,	America White, e		
92	hours aff tural', or al Exami	þ	3 XWidowed 4 □ Divorced	If Yes Give 41	:		1 ☐ Yes 2 ☑ No	Specify:			Specify:	Whit	te	
215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. ad differ than "netural", or tlems 23a or 28e-f show dother than "netural", or tlems 23a or 28e-f show event. The Medical Examinar must be notified at	Completed	15. Deceden (Specify only highe	it's Education st grade completed)		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retire	oation during most	of working	16b.	Kind of Busi	ness/Indu	ustry	
121	within ene. than	dmc	Elementary/Secondary (0-12)	College (1-4or	5+)		sewife	<i>a)</i>		Но	memake	or.		
ב פר	_ 0 9	BeC	17. Father's Name (First, Middle,	Last)		Hous	CNILC	18. Mothe	r's Name (First, Midd					
ylar	Men Arke arke	ToE	Harry Lee Ste						rie Mae Mo					
Maryland	h ar		19a. Informant's Name/Relations				•		or or Rural Route Num				Code)	
	of Healt item 2		Mary D. Shaff - 20a. Method of Disposition		20b. Pla		osition (Name of matory or other pla		nrersville Date		Location - Ci		vn, State	
altimore,	0 0		17 Burial 2 ☐ Cremation `4 ☐ Donation 5 ☐ Other (S		9				4/12/06	Bu	rkitts	vill	e. MD	ý
3alti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service	Licensea		22	2. Name and Addre							
	20 E 9 0		23a. Part1. Enter the disease, o	r condications that cause		Do not ent	er the mode of dvi	ng such as	Harpers		y, WV		25 Approximat	te
	Dhysisian		shock, or heart failure. List Immediate Cause (Final	only one cause on each	line.			3 ,	,				Onset and I	Death
	Physician /Medical		disease or condition resulting in death)	Due to (or a	a conseque								7708	, 3
	Examiner		Sequentially list conditions,	b. CHF								_	mo's)
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	,	s a conseque	ence or):							y	3
o,	te be executed ysician and te burial-transit		that initiated events resulting in death) Last	Ü	s a conseque	ence of):								
8760	P Sy Bd	licai		d. To be	acco	uje						-	yes	us
9 XO	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as I	Physician/Med	IF FEMALE:	23c. If yes, outcom	e of pregnan	ncv					23d. Date	of deliver	rv.	
8	death e a atten	ician	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant	2 Fetal	death 3[Ectopic pregnand Other (specify)	у			Month			Year
0	at the de by the a	hys	9 🗆 Unknown	9□ Unknown										
	ires tha signed I d be det	b	Part II. Other significant conditi	ons contributing to death	but not resul	iting in the u	nderlying cause gi	ven in Part I.			o use contrib 2 □ No 3		ably 4 ⊡l	
ecords,	w require been st	letec							24a. W	as an	24b. We	re autop	sy findings	available
Œ	The lav	Completed							— au pe 1 ☐ Yes	topsy rformed? 2 1271	dea	or to com ath?]Yes 2	npletion of c 2□ No	ause of
ita		BeC	25. Was case referred to medica examiner?						of Death (Check onl	-/- 1				
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O	ding h. Afte fune	ation	1 ■Natural 5 □ Pendi	/A formation C	ay Year)	Injury	Wo	rk?]Yes 2 □ l			, , , , , , , , , , , , , , , , , , , ,			
Division of Vital		Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 286. Place of I	njury - At hor etc. (Specify)		reet, factory, office			(Street Town, Sta	and Number ate)	or Rural	Route Num	nber,
۵	ospitel or hours aft unerel Di ly filled in								d sleep, and due to the		/-\d			
	H 22 H	edical	29a. Certifier 1 Certifyi (Check only 2 Medical one)	ng Physician: To the bes Examiner: On the basis and manner:	of examinati	viedge, deat ion and/or in	n occurred at the t vestigation, in my	me, date an opinion, dea	th occurred at the tim	e, date a	(s) and mann and place, an	d due to	the cause(s	5)
	To the within To the Comple	Me	29b. Signature and title of certific				29c. Licen	se number		29d. [Date signed (Month, D	lay, Year)	
			Nay	ms cm			2127	8		Apr	il 10,	200)6	
1	2		30. Name and address of poor					Form	, <u>ιπι ο</u> ξλο	5				
	St	ate	Lloyd Tracy, N 31. Date filed (Month, Day, Year	1D - 31 Tay1	or Str strar's Signati	ure .	· narpers	rerry	y, WV Z34Z	ر				
	Regist		WAKK]	L 1 2006	due	K,	Sperke							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MELVIN RUDOLPH HAUGH April 12:10 P M 2006 6, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 620 Morelock Schoolhouse Road Carroll Westminster 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 21, 1928 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) Days 1 XM 2□ F Hours 220-28-8914 78 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Maryland Carrol1 Westminster 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 620 Morelock Schoolhouse Road 21158 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ঐYes 2 □ No If Yes, Give Year or Dates: Korean 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 Ĭ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dairy, Farmer Farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Hamilton Haugh Hilda Mahala Fox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda J. Geiser / Daughter 9011 Spring Meadow Circle, Frederick, MD 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State * 4 □ Donation 5 □ Other (Specify) Smithsburg Crematory 4/14/06 Smithsburg, Maryland 21. Signatura Tura al Service 22 Name and Address of Facility & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 tions that caus 23a. Part1. Enter the disease, or complica e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Prostate Due to (or as a consequence of): Sequentially list conditions, if any learning training cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of)

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

, or items 23a or 28e-f show

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al Hygiene.

rmit. Pages 1 and 2 should be file partment of Health and Mental Hy portent: If item 27 Is marked oth y injury or other treumetic event

permit. Page Department o Importent: If eny injury or once.

other treumetic event, I've Madical Example

Director

Funeral

Be Completed by

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

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Division of Vital Records, P.O. Box 68760,	ospital or Attending Physicien: The law requires that the death certificate be executed	. hours after death. unorel Director: After this certificate has been signed by the attending physician and sly filled in by the funeral director, page 2 should be detached for use as the burial-transit	cal Certification: To Be Completed by Physiclan/Medical Examine

	d	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significant condition	4	id tobacco use contribute to the cause of death?
<u></u>	None Khowh	Yes 2 No 3 Probably 4 Miknown
		utopsy prior to completion of cause of death?
25. Was case referred to medical examiner?	26. Place of Death (Check on	ly one)
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 R	esidence 6 Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of Injury (Month, Day Year) 28b. Time of lnjury at Work? 28d. Descrit	be how injury occurred
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	286, Place of Injury - At home, farm, street, factory, office 281, Location	n (Street and Number or Rural Route Number, Town, State)
	Physician: To the best of my knowledge, death occurred at the time, date and place, and due to t xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time and manner stated.	
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
1 Horand	Javort, M.P. 15552	4/7/06

Street WESTMINSTER, HID 21157

Registrar DHMH 17 Rev 1/2001

State

355 South Center.

person who completed cause of death (Item 23a) (Type, Print)

			_ For								ental Hyg	•	gible.	0007
			1 - State Registrar			Cei	tificat	e of L	Death			g. No.	16 1	2341
	Physici	an.	Decedent's Name (First, Middle, La	,							Date of Deat Month	h Day	Year	3. Time of Death
	/Medic		Eunice Virginia								April		2006	7:37 A ^M
	Examin	ier	4a. Facility Name (If not institution, given Frederick Memorics)				-		Location o	f Death			nty of Death	.1.
	.		5. Social Security Number 6. S		Age (In yrs. I	ast birthday)	If Under	redei	If Under 2	24 Hrs.	8. Date of Birth	1	ederic	
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Funeral Director		-	1□M 2 ∑ F	92	Yrs.	Months	Days	Hours	Min.	(Month, Day, July 30,		Cour	olace (State or Foreign otry) Cginia
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	arylar show dat	-	10a. State 10b. County			, Town or Lo							1	0d. Inside City Limits 1 Yes 2 No
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	with t	급	10e. Street and Number 201 E. ridgevill	o 10.1-1-4			10f. Zip		771		1		of What Cour	
	ne 23	eral	11. Marital Status	12. Was Decede	ent Ever in U.	S. 13. \	Was Dece			in? (Spec	cify Yes or No-		ted St	
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93	ral', c	1 by	3 Widowed 4 Divorced	If Yes, Give Year or Date	s:		1 🗌 Yes	2 X No	Ѕреспу:			Spe	cify: Wh	ite
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or Itema 23e or 28a-f ahow ne Maryland Examirer must be no lifted at	Completed by Funeral Director	15. Decedent's E (Specify only highest gr.			16a. Deced (Give	kind of wo	rk done a	lurina most	of workin	g	16b. Kind of	Business/In	dustry
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d 2	Hygie Hygie other	ပိ	17. Father's Name (First, Middle, Last	")		пс	mema.	ker	18. Mothe	r's Name	(First, Middle, M		wn Hon	ie
an	ld be ental ked o	To Be	Reece Patrick H	i1t					L.	ila P	atrick			
Maryland	should be fand Mental had marked of	-	19a. Informant's Name/Relationship (19b. Mailir	ng Address	(Street a			Route Number,	City or Tox	vn, State, Zip	Code)
	and 2 Balth a n 27 Is		Frank Starritt H	o1mes/Hus	band	201	E. R	ideev	/ille	B1vd	l. Mt.	Airy,	Mary1	and 21771
ore	of He	l. Y	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from Sta		lace of Dispo emetery, crer	sition (Name	me of other place	9)			20c. Locatio	n - City or To	own, State
E de get 4 Donation 5 Other (Specify) Pine Grove Cemetery 2006 Mt. Airy, Mar									ryland					
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	905 4 Q		Y L	<i></i>						Blvd	. Mt.	Airy,	Mary1	and 21771
35.			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	\sim			er the mod	ie or dylni	g, such as i	cardiac or	respiratory arre	ist,		Approximate Interval Between Onset and Death
*	Physician /Medical		disease or condition resulting in death)		umor									IWEEK
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9 X	Physician: The law requires that the death certifica this certificate has been signed by the attending phrat director, page 2 should be detached for use as the	Physician/Med	IF FEMALE:	23c. If yes, outcor	me of pregna	ncy						234 I	Date of delive	20/
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ord	w require been si should b	ted	HYPERTENSTON								1 🗆 Ye	s 2 200	3 Prob	pably 4 Unknown
Records,	e law r has be ge 2 sh	Completed	HIGH CHOCESTE	EROC							24a. Was ar autops	V	b. Were auto	psy findings available mpletion of cause of
E E	cate h	Con	DEMENITA								perform 1 ☐ Yes 8		death?	2 No
Vital	ician certifi ector	Be	25. Was case referred to medical examiner?	Hospital:				Othe	ar.		(Check only on			
of		. To	1 Yes 250No	28a. Date of I		ER/Outpatien 28b. Time of		JA J.	4 🗆 1901		e 5 Reside			(y)
on	ding th. : Afte	tlon	1 Accident 5 Pending 2 Accident Investigation	(Month,	Day Year)	Injury	м	28c. Injury Work 1 🗀 `	? /es 2 □ l			,,		
Division	Attending death.	Ifica	3 Suicide 6 Could not b	28e. Place of	Injury - At ho	me, farm, str	eet, factor	y, office		2	8f. Location (St.	reet and Nu	mber or Rura	al Route Number,
Ö	s afte s afte al Dir	Certification:	4 Notticide	bullaing,	, etc. (Specify	′)					City or Town	, State)		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune		29a. Certifier 1 Certifying P	hysician: To the be	est of my know	wledge, death	occurred	at the tim	e, date and	d place, as	nd due to the ca	use(s) and	manner as s	tated.
	the hin 24 the F	Medical	one)	and manner	stated.			c. License						
	With 0	~	29b. Signature and title of certifier	/	2				007	5-	25	9d. Date sig	ned (Month,	Day, Tedi)
,	6		many P. ts			22a) (T		110				110	106	
·	/ >		30. Name and add of person who Mary P. Howell,	M.D. 65	of death (Item C Thom			Driv	re T	Trede	rick, M	arv1 21	nd 217	02
	Sta	ite	31. Date filed (Month, Pap. Year)	2006 32. 2 9	istrar's Signa	ture		~ L T V	- 1	LCuc	LICK, II	ar y rai	.u 41/	
180	Registr		7111	LUUD	istrar's Signa	IS A	rock	-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Donna Mae Hopkins April 6, 1:50 p M 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Country Companions Taneytown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Feb 16, 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🔀 F 215-42-9059 65 Director Maryland Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Heatth and Mental Hygiene. em 27 is marked other than "natural", or Itema 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Itema 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at Carroll Westminster 1 ☐ Yes 2☐ No Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21158 USA 1701 Richardson Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 KNo Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry County Elementary/Secondary (0-12) Coflege (1-4or 5+) Director of Nursing Health Dept. $5 \pm$ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be AARON J. SHAFFER HELEN WITTE 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health at
Important: If item 27 is
any injury or other trau Howard P. Hopkins, husband 1701 Richardson Road, Westminster, MD 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 04/07 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Winfield, MD South Carroll Crematory 2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home M01191 91 Willis Street, Westminster, MD 21157 23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Meta Colon **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE 23c. ff yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Niknown Knowh Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 Yes 2 No 1 ☐ Yes 2 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Assisted Hospital: Other: 4 Nursing Home 5 Residence 6 Wother (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 015552 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print). Freat Wastminster, MS 21157 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

DHMH 17 HeV 1/2001

EDNA MAY HAINES Baltimore, Maryland 21215-0036

	134		Please 1 - For Registrar		ryland / Dep		Ensure All Copie ealth and Mental H	ygiene 06	12929					
	Physici		Registrar Decedent's Name (First, Middle, La Edna May Haines		Ce	Timcale of L	2. Date of Month	Day Yea	3. Time of Death					
	/Medic Examin		4a. Facility Name (If not institution, give	e street and number)			Location of Death	4c. County of De	ath					
Ĺ	Funeral Director		5. Social Security Number 6. S 215-32-8122 Usual Residence of Decedent	ex 7. Age □ M 2 12 F	(In yrs. last birthday, 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. 8. Date of Month, Aug. 1		irthplace (State or Foreign Country) ryland					
	Ba-f show	ctor	Penna. 10b. County York		10c. City, Town or L		obottstown		10d. Inside City Limits 1 ☐ Yes 2 ▼No					
	ath with th	Funeral Director	10e. Street and Number 117 Frog Pond Hol	r		10f. Zip Code	17301	10g. Citizen of What C						
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "netural", or items 23a or 28a-1 show any injury or other traumatic event, if a McJical Exartin at Lorel by nufficial at ance.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☑ No	spanic Origin? (Specify Yes or n, Mexican, Puerto Rican, etc.) Specify:	0 1	nerican Indian, nite, etc. white					
21215-0036	within 72 ho ene. than "natur ive Medical	Completed	15. Decedent's E (Specify only highest gra	ducation de completed) College (1-4or 5-	(Give	edent's Usual Occupa e kind of work done d DO NOT use retired; Clerk	ation furing most of working)	16b. Kind of Busines County Circuit	,					
Maryland 2	uld be filed Mental Hygli irkad othar itic evant, I	To Be Co	12 17. Father's Name (First, Middle, Last John F. Ges				18. Mother's Name (First, Midde Margaret E.							
e, Mary	and 2 sho lealth and ! m 27 is me har traums			Zip Codθ)										
Baltimore,	t. Pages 1 tment of H tant: If its ijury or ot		Doris L. Haines, daughter 19 Courier Drive, Taneytown, MD 21787 20a. Method of Disposition 11 Burial 2 Cremation 3 Removal from State 14 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Evergreen Memorial 20c. Location - City or Town (Aughts) 20c. Location - City or Town (Aug											
Bal	permit. Pa Departmen Important: eny Injury		21. Signature of Funeral Service Lice	Duton			Street, West		21157					
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	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated execute.	b. Due to (or as a	b. Due to (or as a consequence of):									
68760,	icate be executed physician and s the burial-transit		that initiated events resulting in death) Last C. Due to (or as a consequence of):											
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	w requires that been signed b should be deta	þ	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the t	underlying cause give		d tobacco use contribute	to the cause of death? Probably 4 Unknown					
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sion of	Attending Phy r death. actor; After this by the funeral o		27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day	28b. Time o	of 28c. Injury Work		e how injury occurred	ocity)					
Division	Dir G	Certification;	3 Suicide 6 Could not b	building, etc.			City or 1	(Street and Number or I own, State)						
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier	ysician: To the best o niner: On the basis of and manner stat	examination and/or it	th occurred at the time envestigation, in my op 29c. License	e, date and place, and due to the time	e, date and place, and du	ue to the cause(s)					
)	MUN			me	<u></u>		30263		26-06					

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCIS KHOO CAPROLL HOSPITAL CENTER,

FRANCIS KHOO CA
31. Date filed (Month, Day, Year)
APR 0 7 2006

ZOO MEMORIAL AVE, WESTHINSTER, MD 21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Dorothy Hall 04042006 9:30p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 709 Redwood Drive Westminster Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07-20-1929 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□M 2√2F 76 Director Maryland 218-24-9681 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examinar must be notified at 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ➡No Completed by Funeral Director Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 709 Redwood Drive 21157 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Assembly Line Worker Random House Books 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wisner Walter Preston ၉ Lillian Lambert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Depertment of Health a Important: If Item 27 is any injury or other training. A. Richard Hall - Husband 709 Redwood Dr., Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State Hampstead Cem. 04-08-06 4 ☐ Donation 5 ☐ Other (Specify) Hampstead, MD 22. Name and Address of Facility Eline Funeral Home Tach MO0550 934 S. Main St., Hampstead, MD 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 72/6m Physician months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-trai resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No : After this certification of the transfer of 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification; To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

Philly

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6.11

APR 0 7 2006

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32/Registrar's Signature

06-02574 Bradley Hagner

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death	Reg	No. 2006	12931	
Physicia Medical Exami			2. Date of Death Month Day Year April 16 2006 1149 hrs			
Wedical Exami	i ici	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	April 16, 20	4c. County of Deatl		
		26 Ward Avenue Westminster		Carroll		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	_	(MM/DD/YYYY) 9. Bir		
Director		217-19-5153 1 X M 2 F 29 Yrs. Months Days Hours Min.	02/16/	1977 Foreign	untry) MD	
ž		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d Inside City Limits	
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e, M I and 2 Health item 2	1	20a Method of Disposition 20b. Place of Disposition (Name of cemetery,		20c. Location - City or		
Baltimore, MD 2121 permit Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event,		1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: \$ Carroll Crematory 4/18,	/2006	Winfield,	MD	
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J. m		3 Name and address of person who completed a jause death (Item 23a)	310			
NO	ļ	Theodore King MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	1201			
	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
Regist	rar	APR 1 9 2006 Mayor & Joseph				

6-02546			Please Type o									
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Physician	1/	Registrar 1. Decedent's Name (First, Middle,Last)						Date of Death Month Day Year		3. Time of Death		
Medical Examin		Steven Mart		Hilgenberg				Apr	il 14, 200	06	2040 hrs	
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Director		5. Social Security Number 6. Sex 7. Age (In yrs last birthday) 1 I I I I I I I I I I I I I I I I I I						reign Washingto Country D.C.				
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sion of Vital Records, P.O. Box 68760, terending Physician: The law requires that the death certificate be executed. After this certificate has been signed by the attending physician any the funeral director, page 2 should be deached for use as the burial - tri	ation:	1 Natural 5 Pending 2 X Accident Investigation	FNd 4/14/2006	Fnd	8:15 P	M 1	Yes 2 X	No driv	ing eri eafter	ratically; <u>found</u> in b	snortly urning vehicle	

Division

To the Hospital or Attend
within 24 hours after death
To the Funeral Director:
completely filled in by the f

Medical Certificat 3 29a. Certifier 1 (Check only one) 2

State Registrar

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Registrar's Signature 31. Date filed (Month, Day Year) 2006

(Specify)

and manner stated

road

6 Could not be

Suicide

Homicide

Susan Hogan MD.

28f Location (Street and Number of Rural Route Number, City Davidsonville, MD24 & Patuxent River

April 15, 2006

29d Date signed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

> 29c. License number O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2006 Month Year **Physician** Robert Lafoon Hill April 6, 7:25 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Sligo Creek Nursing Home Takoma Park Montgomery 8. Date of Birth (Month, Day, Year) Tully 18, 1 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 15₹M 2 ☐ F 578-28-3949 80 1925 Director Wash. D.C. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show other treumatic event, the Mudical Examiner must be notified at 1 ▼Yes 2 No Director Chillum Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 905 Luray Place 20783 naturel', or items 23a United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 \(\times \) No 1943-14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 K Divorced 1946 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Department of College (1-4or 5+) Elementary/Secondary (0-12) Transportation/Fed. File Supervisor is marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked othin any higg or other treumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Russell Hill Margaret Dishman 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon H. Walker (daughter) 905 Luray Pl., Chillum, MD 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □Donation 5 □ Other (Specify) 4/13/06 Lincoln Memorial Suitland, MD 22. Name and Address of Faciliting Guire Funeral Service 21. Signature of Funeral Service Licenses omo 7400 Georgia Ave. N.W., Wash. D.C. 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Myocardial Infarction /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an 2₺ No 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: MI Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division 5 Pending 1 Natural death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a To the Funeref Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D45471 April 10, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yeheyis Negussie, M.D. 1111 Spring Street, Silver Spring, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 Registrar

		201	1 - For State Registrar	State of	Marylan		artment <i>tificate</i>			and M	lental Hyg	iene eg. No.	6	12934
	Physici		1. Decedent's Name (First, Middle, La Edith Julia H	^{ist)} odge							2. Date of Dea Month	Day	Year 2006	3. Time of Death 5:01 PM
	/Medic Examir			ional	Hospi-		4b. City, T	La	urel			4c. Coun	ty of Death	George's
	Funeral Director		237-48-0034	Sex 7 1 □ M 23x F	. Age (In yrs.	71 Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birth (Month, Day June 14		9. Birthp Cour Nor	place (State or Foreign htry) th Carolina
	Maryland a-f show	tor	Usual Residence of Decedent	mery		y, Town or Lo Wheator							1	10d. Inside City Limits 1 ☐ Yes 2 ▼ No
	with the	Director	10e. Street and Number 11926 Centerhill	Street			10f. Zip (1	0g. Citizen o		ntry?
036	4 within 72 hours after death with the Maryland Jiene. r then "natural", or Items 23a or 28a-1 show The Medical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Deced Armed Ford 1 Yes 2 If Yes, Give	es? X∑X No		Was Decede	ent of His fy Cubar	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	14. Ra BI	ace - Americ lack, White, hityWhite	etc.
Maryland 21215-0036	d within giene. or then "	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		4or 5+)	(Give life.	dent's Usual kind of work DO NOT use emaker	k done d e retired)	tion u <i>ring</i> most	of worki	ng	16b. Kind of	Business/In	
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	I and 2 sho lealth and im 27 Is m		19a. Informant's Name/Relationship Debbie Hodge/ 20a. Method of Disposition 1⊠ Burial 2 □ Cremation 3 {	Daughter			26 Cer	terl	nill			aton, 20c. Location	MD 205 - City or To	9(1F_ own, State
Baltimore,	permit. Pages Department of H Importent: If Its any injury or of		4 Donation 5 Other (Speci	(y)	Gat	e of Hea	Name and	Addres	e e e e e	ins	Funeral	Home	Inc	ng, Maryland , MD 20901
8760,	death certificate be executed National Market Secure of the Control of the Contr	dical Examiner	23a. Par1. Enter the "sease, or con shock, or heart fail" re. List only Immediate Cause, disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	r as a consequent as a consequ	uence of):	er the mode	C S		100 100	MP			Approximate Interval Between Onset and Death
P.O. Box 6		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		th 2 Fetal nt at time of de	Ideath 3	Ectopic pre Other (spe						ate of delive	ery Day Year
	w requires that the sbeen signed by the should be detache	þ	Part II. Other significant conditions	contributing to dea	th but not resu	ulting in the u	nderlying ca	use give	n in Part I.			pacco use co	ntribute to th	ne cause of death?
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Division of Vital Records,	ding Phys h. After this funeral di	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of (Month,		ER/Outpatien 28b. Time of Injury		lc. Injury Work	r: 4 □ Nui	rsing Ho	n (Check only on me 5 ☐ Reside 28d. Describe ho	ence 6 🗆 O		ý)
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	he Hospital in 24 hours a he Funerel t pletely filled	edical	29a. Certifying P (Check only one) Check only 2 Medical Exa	hysician: To the b miner: On the bas and manne	is of examinal	wledge, death tion and/or in	occurred a restigation,	t the time	e, date and inion, deat	d place, a	and due to the ca ed at the time, d	ause(s) and n ate and place	nanner as s	tated. o the cause(s)
)	To the half	M	29b. Signature and title of certifier	Lale	lan	r	29c.	License	number 285	95-	2	9d. Date sign	led (Month,	Day, Year)
			30. Name and address of person who	completed cause	of death (Item	7 2.	Print)	PA	RK	He	4 Coto	SA	VE, E	BARD MI)
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1	Examin		4a. Facility Name (If not institution, give st			4b. City, To	wn, or Loc	ation of De	ath	4	lc. County	of Death	1	
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٥	or its	F	1 ☐ Never Married 2 ☒ Married	1 ☐ Yes 2 ☒ No If Yes, Give		1 ☐ Yes 2 🛭				,	Specif		510.	
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saltimore,	permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury go other traumetic even once.		21. Signature of Funeral Service License	9	S22	Name and and imple	Address of	Facility Fe Fr	meral	and C	remat	ion (lenter	
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	/Medical		resulting in death)	Due to (or as a conse		arrure								
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	To tha Hos within 24 h To tha Fur completely	edical		er: On the basis of examinand manner stated.										
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	3		30. Name and address of person who con	noleted cause of death (Ite	m 23a) (Type					P				
			Anushiravan Dadgar		Medica	•	er D	r #20	1: Roc	kville	e, MD	208	50	
	Sta	ite		32 Registrar's Sign	aturo			. ,, 20			.,			
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			For State	State of Ma	aryland / (•	nent of F	lealth and M	lental Hy	200	16	12936
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A	Funeral		5. Social Security Number 6.	Sex 7. Aga 1 ☐ M 2 ☐ XF	e (In yrs. last bir	Mo	Jnder 1 Year nths Days	If Under 24 Hrs. \	8. Date of Bir (Month, Da	th ay, Year)	9. Birthp	place (State or Foreign
	Director		213-00-0329	1Um 2UAF	48	Yrs.			May 13	, 1957		aryland
	and wo		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Locatio	n				1	Od. Inside City Limits
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	15 wit		632 N. Stoke	es Street				21078			USA	
	r dee	Funerai	11. Marital Status	12. Was Decedent Armed Forces?		13. Was	Decedent of F	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Raci	e - Americ k, White.	can Indian,
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5	hour land		15. Decedent's E	Year or Dates:	16a	Decedent	Usual Occup	nation		16b. Kind of Bu		
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Batimore Maryland 21215-0036	permit. Pages 1 and 2 should be flied within 72 hours after deeth with the Maryland Department of Heelih and Mental Hygiene. Department of Heelih and Mental Hygiene. If I time 27 is marked other than "natural", or I tama 23s or 28s-f show any injury or other traumatic avant. The Madical Examinar must be notified at once.		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		20b. Place of cemeter.		_	l		Havre de		
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3	Physician		Immediate Cause (Final disease or condition	. 14	ASO	UB					10	Onset and Death
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1 C	. 5 .5	by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death		er (specify) _			Mor	ប្រា	Day Year
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THAN AY Division	2 g ig c	Certification;	4 Homicide determined		u ry - At home, fa c. <i>(Specify)</i>	ırm, street, f	actory, office		28f. Location (. City or To	Street and Numbe vn, State)	er or Rura	I Route Number,
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7	To the Hospitel within 24 hours a To the Funeral I completely filled	ledicai	(Check only 2 Medical Exa	miner: On the basis of and manner sta	f examination an	d/or investig	ation, in my o	pinion, death occurr	ed at the time,	date and place, a	ind due to	the cause(s)
	To the To the Comp	X	29b. Signature and title of certifier				29c. Licens			29d. Date signed	(Month,	Day, Year)
			- yourship	whhu	M.D	<u></u>	0-	21809		AME	bil 2	2006
	5		30. Name an address of person who	completed cause of d				MONIL				
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	Registr		31. Data (iba Month, Day, Year)	Blown &	ar's Signatura	Le la la la la la la la la la la la la la						

			1 - For State Registrar		State of	Maryla		artmer rtificat				ental Hy	giene	6	12937	
ч	Physici	an	Decedent's Name (First,	Middle, Lasi)							2. Date of Dea Month	ath Day	Year	3. Time of Death	
	/Medio		BARRY F	411								APRIL	6	2006	908A N	A
	Examir	ier	4a. Facility Name (If not ins		street and nun	nber)		_		Location of			4c. Count			
£.	Funeral		5. Social Security Number	1174L	x	7. Age (In yrs	. last birthday)		1 Year	If Under	24 Hrs.	8. Date of Birt	Ch		lace (State or Foreig	
	Director		558-53-1428	1 0	Ú M 2□F	3 , , ,	43 Yrs.	Months	Days	Hours	Min.	8. Date of Birt Jan . 1	4. 1963	Low	lace (State or Foreig try) Siana	,,
	pu ,		Usual Residence of Deced			10.0										
	shoy	5	10a. State 10b. C		• 0	10c. C	ity, Town or Lo							1	0d. Inside City Limits 1 ☐ Yes 2 🕱 No	
	with the Maryland a or 28a-f show	ecto	Maryland 10e. Street and Number	Cec	u		Rising		0-1-	-						_
	with Be or	Funeral Director		Cinal				10f. Zip		1011			10g. Citizen of		try?	
	me 23	era	306 Sunrise	Collect	12. Was Dece	dent Ever in t	J.S. 13.	Was Dece		1911 spanic Ori	gin? (Spe	cify Yes or No-	US	A ce - Americ	an Indian	_
٥	or its	Ē	1 Never Married 2] Married	Armed For 1 ☐ Yes	2 🔀 No	1				i, Puerto F	cify Yes or No- Rican, etc.)		ck, White,	etc.	
2-003b	hours after death with the Maryland tural', or Itame 23a or 28a-f show at Exeminet must be notilised at	d by	3 ☐ Widowed 4 ☐ Div	orced	If Yes, Give Year or Da	tes:		1 🗆 Yes	2ì ∠ No	Specify:			Specia	r: Whit	te	
בֿ	22 8 3	Completed	15. De (Specify only	edent's Edu highest grad			16a. Dece (Give	dent's Usua kind of wo DO NOT u	al Occupa rk done d	tion uring mosi	t of workir	ng	16b. Kind of E	lusiness/Ind	lustry	
7	within ene. than "	dmo	Elementary/Secondary (0	-12)	College (1-	4or 5+)		.ksmi					Horse	Dan i	14.0	
ט ט	filed Hygi other	ပိ	17. Father's Name (First, M	iddle, Last)	,		bruc	.icsiiica	-11	18. Mothe	r's Name	(First, Middle,			ng	_
a	lid be lental ked c	To Be	Elden Hall									Burnett		,		
aZ	e mar		19a. Informant's Name/Rei	ationship (T)	/pe, Print)		19b. Mailie	ng Address	(Street a	nd Numbe	or Rura	l Route Numbe	r, City or Town	, State, Zip	Code)	_
Ξ.	end 2 salth n 27 I		Myra J. Hal	e/wife	2		306	Sunra	ise C	ircle	e, Ri	ising Su	un, MD	21911		
ore Ore	iges 1 en it of Heal if item 2 or other		20a. Method of Disposition 1 🕱 Burial 2 ☐ Crem	ation 3 □F	Removal from S	20b.	Place of Dispo cemetery, cret	sition (Nar matory or c	ne of ther place)	D	ate	20c. Location	- City or To	wn, State	
III III O	mit. Pag partment cortant: injury c		4 □Donation 5 □Ot	ner (Specify)		Br	ookive								Maryland	
a D	permit. Pag Department Important: I any injury o		21 Signature of Funeral Se	rvice Licens		ad:	22 R	. Name ar	d Address Foar	d Full	y neral	Home, Risi	P.A.			
	30		23a. Part 1. Enter the disea shock, or heart failure	se or compl	lications/that ca	used the dea	th. Do not ent	11 S.	Que	en S	treet	, Risi	ng Sun,	MD 2	1911 Approximate	_
00/00,	Physician pe executed diud physician and as the purial-transit transit	ilcal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	{	b. Self Due to (c) Due to (c)	S i S or as a consec	Quence of):		OCCA	(/0	'~S	INFR	CN'U~		Onset and Death WEEK WEEK WEEK WEEK	
O DOX O	The law requires that the death certificate has been signed by the attending place 2 should be detached for use as t	Physiclan/Med	IF FEMALE: 23b. Was decedent pregna in the past 12 months' 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	16		th 2 ☐ Feta int at time of c	al death 3	Ectopic pr						ite of delive	ry Day Year	
, L	es tha gned to	by P	Part II. Other significant co	nditions co	ntnbuting to dea	ath but not res	sulting in the u	nderlying c	ause givei	n in Part I.		23e. Did to	bacco use con	tribute to th	e cause of death?	
cords,	w require been sign should b	ted										1 🗆 Y	es 2⊡No	3 Proba	ably 4 Unknown	
	sicien: The law s certificate has b firector, page 2 sf	Completed									-	24a. Was a autops perfor	med?_	Were autop prior to con death? 1 \(\sum \text{Yes}\)	esy findings available apletion of cause of	ì
VII	sicle: certi	o Be	25. Was case referred to m examiner? 1 Yes 2 No		lospital:	patient 2	IFD/O		Δ Other			(Check only or				
5	Phy er this	n: To	27. Manner of Death	1	28a. Date of		ER/Outpatien 28b. Time of		Bc. Injury Work	7 🗆 1401		ne 5 Resid)	_
10121	ath. r: Aft	atlo	2 Accident	ending vestigation	(Month	, Day Year)	Injury	М		? es 2∐N	No					
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Certification;		ould not be etermined	28e. Place o	of Injury - At h g, etc. (Special	ome, farm, str	eet, factory	, office		2	8f. Location (S City or Town	treet and Numb n, State)	er or Rural	Route Number,	_
	To the Hospitel within 24 hours a To the Funerel Completely filled	edical	29a. Certifier 1 de Ce (Check only one) 2 de Me	tifying Phy dical Exemi	sician: To the t ner: On the bas and manne	sis of examina	owledge, death ation and/or inv	occurred estigation,	at the time in my opi	o, date and nion, deat	d place, as h occurre	nd due to the c d at the time, d	ause(s) and ma ate and place,	anner as sta and due to	ited. the cause(s)	
	To T com	Σ	29b. Signature and title of c	ertifier					. License				9d. Date signe			
•			'WE	//	m	- / /	M			627			April	6 20	06	
	4		30. Name and address of po		mpleted cause	of death (Iter	n 23a) (Type,	Print)							-	
	Sta	te×	31. Date filed (Month, Day,	Year)	/ (VV)	gistrar's Signa	n 23a) (Type, Street	The	(N)	M	rylan	2				_
	Registr		31. Date filed (Month, Day, APR 1 1 20	06 🔏	(succes	K 4	mede									

			1 - For State Registrar	-		d / Depa		lealth a	nd Mental I		eno	6	12938
E	Physici	an	Decedent's Name (First, Middle, Last,)		-			2. Date of Month		Day	Year	3. Time of Death
	/Medi			n L. Hurc					Apri]	8	200		21:12 ^M
	Examir	er	4a. Facility Name (If not institution, give Howard County Gene				4b. City, Town, o		Death		4c. County o	_	
£	Funeral		5. Social Security Number 6. Sec			ast birthday)	Colun If Under 1 Year	IDLA If Under 2		Birth	Howar		place (State or Foreign
Make	Director			X M 2□ F	58	Yrs.	Months Days	Hours	June	Day, Yea			yland
	anylan show	<u></u>	10a. State 10b. County		10c. City	r, Town or Lo	ocation					1	Od. Inside City Limits
	8a-f	cto	MD Howard		El]	Licott							1 ☐ Yes 2√2 No
	with the	Funeral Director	10e. Street and Number				10f. Zip Code				Citizen of WI		•
	leath	eral	8438 Merryman St.	12. Was Decedent	Ever in U.	S. 13.	21043	lispanic Orig	in? (Specify Yes o		ited S		ean fndian.
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Example per intelligible and once.	by	1 Never Married 2 X Married 3 Widowed 4 Divorced	Armed Forces? 1 XYes 2 If Yes, Give Year or Dates:	No		If Yes, specify Cuba 1 ☐ Yes 2 ☑ No		in? (Specify Yes of Puerto Rican, etc.)	Specify:	White,	
Ŏ S	72 ho	Completed	15. Decedent's Edu (Specify only highest grad			16a. Dece	dent's Usual Occup	ation	of working	16b.	Kind of Bus		
21215-0036	ithin 78.	npie	Elementary/Secondary (0-12)	Coflege (1-4or	5+)		kind of work done DO NOT use retired	d)	GI WOIKING				
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Ë	thould do mark mark matic	2	19a. Informant's Name/Relationship (Ty	roe Print)		19b Maili			Catherine			tate Zin	Code)
	ath an strain train		Cathy E. Hurd/Wife	, , , , , , ,					Ellicott				
Ē,	f Healitem		20a. Method of Disposition		20b. Pl	ace of Dispo	sition (Name of matory or other place		Date	1/4	Location - C		
Ë	Pages nent of I ant: If it		1 ☐ Burial 2 ☆Cremation 3 ☐ F 14 ☐ Donation 5 ☐ Other (Specify)	Removal from State		-	ematory	1	4-13-2006	Ca	atonsv	i 11e	- MD
Baltimore,	permit. Departm Importa any inju	5	21. Signature of Funeral Service Licens	- with	M0104	4 2	2. Name and Addre	ss of Facility		Wit:	ke's	Fami	ly FH Inc
	17.00		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused ne cause on each li	d the deeth	. Do not ent	er the mode of dyin	ng, such as c	ardiac or respirator	y arrest,			Approximate Interval Between
	Pnysician	8	Immediate Cause (Final disease or condition						ar Diseas				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as									
	Lamine	<u>.</u>	Sequentially list conditions,	Due to /er co									
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89									SENION - SE				
Вох	that the death certifical ed by the attending phi detached for use as th	Physiclan/Med	230. Was decedent pregnant	3c. If yes, outcome	of pregnar	ncy death 3	Ectopic pregnancy	,			23d. Date	of delive	ry
B	deat	sicle	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant a			Other (specify)			_	Monti	h	Day Year
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5	ding F	ion	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time σ Injury	Wor	k?		be how in	iury occurred	1	
Division	i or Attending after death. Director: After in by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	28e Place of foi	unv - At ho	me farm etr	eet, factory, office	Yes 2 □ N	-	n (Street	and Number	or Bura	l Route Number,
<u>~</u>	for A after Direct	Certification:	4 ☐ Homicide determined	building, et			eet, ractory, onice			Town, Sta		OI HUIZ	moute values,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one) Certifying Physical Examination	sician: To the best ner: On the basis o and manner st	f examinat	vledge, death ion and/or in	n occurred at the tin vestigation, in my o	ne, date and pinion, death	place, and due to to occurred at the tin	he cause re, date a	(s) and manr nd place, an	ner as st d due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		,		29c. License	e number		29d. [ate signed (Month, I	Day, Year)
	->-0		Best F	Mort	رحم	MD	Do894	49		An	ril 10), 2	006
1	12		30. Name and address of person who co	empleted cause of o	leath (Item	23a) (Type,					+\	- 377	
) ⁶	~~		Bert F. Morton, MI	2802 Mor	ntcla	ir Dri	ve Ellic	ott Ci	ty, MD 21	.043			
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	Registr	ar	APR 1 1 2	006	EAR	1 1	hast,						

State of Maryland / Department of Health and Mental Hygiene For State Ragistra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Month Year **Esther Corraina Hurley** 4:40 A M Apr 1, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Frederick Calvert **Calvert County Nursing Center** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2X F Director 220-16-8431 Yrs. 93 Maryland Mar 8, 1913 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f ehow the Medical Examiner must be notified at MD St. Mary's Calloway 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 44917 Canvas Back Drive 20620 U.S.A permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If frem 27 ie marked other than "natural", or items 23s any injury or other traumatic event, the Modical Examines must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: Black ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Someone Else's Home 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Moses Gross Annie B. Height 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 44917 Canvas Back Drive Calloway, MD 20620 Diana Rivera/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 04/07/06 Prince Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) Carroll Western Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Sewell Funeral Home a Glody Sewell 1451 Dares Beach Road Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician AsThing /Medical Due to (or as a consequence of): Examiner Osteo as twito Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit Dementin the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Depression use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d Date of delivery 2 Fetal death 3 Ectopic pregnancy ò in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Yes No be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 41 Unknown 1 Tyes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ ⊀o 24a. Was an has autopsy performed? Yes 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2₩0 1 Inpatient 2 ER/Outpatient 3 DOA this ieral Director: After th filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: **1**□Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 50290 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 110 120 sp Shall 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State Registrar

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Physici /Medio Examir	al	Decedent's Name (First, Middle, Last) Mahabil S. 4a. Facility Name (If not institution, give street and number)	Joseph 2. Date of De Month April 6	Day Year
Funeral Director	er -	Prince George's Hospital Center 5. Social Security Number 059–48–7809 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthda. 82 Yrs.	Cheverly	Prince Ceorge's Ath Ay, Year) 9. Birthplace (State or Foreign Country)
death with the Maryland ms 23e or 28e-f show	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Parryland Prince George's		10d. Inside City Limits MXYes 2 □ No
th with th 23a or 26 ust be no	al Director	10e. Street and Number 6602 Greenland Street	10f. Zip Code 20737	10g. Citizen of What Country? U.S.A.
_ <u>a</u> <u>a</u> <u>a</u>	by Funeral	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2♥ No Specify:	o- 14. Race - American Indian, Black, White, etc. Specify: West Indies
within 72 ana.	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation le kind of work done during most of working DO NOT use retired) Mechanic	16b. Kind of Business/Industry Saval Foods (Retired)
be file	To Be C	17. Father's Name (First, Middle, Last) Unknown	18. Mother's Name (First, Middle Sookeya Mor	n, Maiden Sumame)
C = 64 F			ling Address (Street and Number or Rural Route Numb 2 Greenland Street Riverdale, Me	
Baltimore, permit. Pages 1 ar Deportment of Hea Important: If them any injury or othe		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	ematory or other place)	
Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. CARDID Resulting in death)		-
50, as axacuted cian and curial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Ser Fure:	ANIAL HEMOR REHAL FAILI E DUORDIER	ARE 10 DAYS
Cart cart	Physician/Med		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
F 5 5 5	ed by PI	Part II. Other significant conditions contributing to death but not resulting in the	1.15485	obacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Dunknown
Tha law Tha law sata has b	Completed by	DINBETTES	24a. Was autor perfo 1 🗆 Yes	
	To Be	25. Was se referred to medical examiner? 1 Yes 2 No Hospital: Inpatient 2 ER/Outpatient	26. Place of Death Check only of onl	
C g at a	Certification:	27. Manner of Dath 13 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	of 28c. Injury at Work? M 1 Yes 2 No	how injury occurred
DIVISIO To the Hospital or Attendit within 24 hours after death. To the Funaral Director: A completely filled in by the fu		4 Homicide determined building, etc. (Specify)	City or Tou	,
the Hosp in 24 hou the Funa spiataly fi	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge deal (Check only one) Certifying Physician: To the best of my knowledge deal (Check only one) Certifying Physician: To the best of my knowledge deal (Check only one) Certifying Physician: To the best of my knowledge deal (Check only one) Certifying Physician: To the best of my knowledge deal (Check only one) Certifying Physician: To the best of my knowledge deal (Check only one) Certifying Physician: To the best of my knowledge deal (Check only one) Certifying Physician: To the best of my knowledge deal (Check only one) Certifying Physician: To the best of my knowledge deal (Check only one) Certifying Physician: To the best of my knowledge deal (Check only one) Certifying Physician: To the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and (Check only one)	ith oppured at the time, data and place, and due to the nvestigation, in my opinion, death occurred at the time,	date and place, and due to the cause(s)
To T To Com	Σ	29b. Signature after title of fertition		29d. Date signed (Month, Day, Year)
X.	1	30. Nam and address of person who completed cause of death (Item 23a) (Type FECIPE C. ROBINSON, M.		es Hospin CTR
Sta Registr	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Per Phy,gc,4/7/06 Certificate of Death Reg. No. 1. Decedant's Name (First, Middle, Last) 2. Date of Death April 01,2005 3. Time of Death Physician eter /Medical 40 Bounty of Death
Montgomeru 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Reath Examiner lakoma ashina 7. Age (In yrs. last birthday) tar Ton If Under 1 Year If Under 24 Hrs. 8. Date of Birth Hours Min. (Month Day 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 620 1 □ M 2 💢 F 3 South 282 -50-620 Usual Residence of Decedent Director Yrs. deeth with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r then "neturel", or freme 23s or 28s-f ehow the Medical Examinar must be notified at Rince George's 1 Yes 2 □ No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20746 Koao a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. Peges 1 end 2 should be filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 0 Never Married 2 ☐ Married Specify African-American Baltimore, Maryland 21215-0036 1 ☐ Yes 2 KNo Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
fyife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. U.S. Government omputer ecla of Health and Mental Hygis Item 27 Is marked other other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) Be 1955 19a. Informant's ame/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura) Route Number, City or Town, State, Zip Code) 5447 2 antam, MD 20706 20b. Place of Disposition (Name of cemetery, crematory of other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Hamportent: If Ite any Injury or of page 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Umanda les -8-06 easant Vallec 21. Signature of Figneral Service Licensee & ASSOC. dress of Facility Huneral Home 23a. Part. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEART **Physician** FAILURE HOURS /Medical Due to (or as a consequence of) Examiner ULMONARY EMBOLUS MASSIVE 7042 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examin or Attending Physician: The law requires that the death certificate be executed ed by the ettending physicien and detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2X No 9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes e 2 autopsy performed? Yes 2 No page certificete 2□ No 1 Yes 1 ☐ Yes director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Dther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA Certification: To ihis within 24 hours after death.

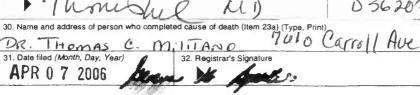
To the Funerel Director: After th
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 18 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D36207 APRIL 1, 2006

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State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) APR 0 7 2006



TAKOMaPKIMO 20912

State of Maryland / Department of Health and Mental Hygierie | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician Year James Leroy Johnson March 28, 2006 9:30 A.M /Medical 4a. Facility Name (If not institution, give street and number)
Calvert Memorial Hospital,
Transitional Care Unit 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Prince Frederick Calvert If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1911 | 9. Birthplace (State or Foreign (Month, Day, Year) | 1911 | 9. Birthplace (State or Foreign (Month, Day, Year) | 1911 | 9. Birthplace (State or Foreign (Month, Day, Year) | 1911 | 9. Birthplace (State or Foreign (Month, Day, Year) | 1911 | 9. Birthplace (State or Foreign (Month, Day, Year) | 1911 | 9. Birthplace (State or Foreign (Month, Day, Year) | 1911 | 9. Birthplace (State or Foreign (Month, Day, Year) | 1911 | 9. Birthplace (State or Foreign (Month, Day, Year) | 1911 | 9. Birthplace (State or Foreign (Month, Day, Year) | 1911 | 9. Birthplace (State or Foreign (Month, Day, Year) | 1911 | 9. Birthplace (State or Foreign (Month, Day, Year) | 1911 | 9. Birthplace (State or Foreign (Month, Day, Year) | 1911 | 9. Birthplace (State or Foreign (Month, Day, Year) | 1911 | 9. Birthplace (State or Foreign (Month, Day, Year) | 1911 | 9. Birthplace (State or Foreign (Month, Day, Year) | 1911 | 9. Birthplace (State or Foreign (Month, Day, Year) | 1911 | 9. Birthplace (State or Foreign (Month, Day, Year) | 1911 | 9. Birthplace (State or Foreign (Month, Day, Year) | 1911 | 9. Birthplace (State or Foreign (Month, Day, Year) | 1911 | 9. Birthplace (Month, Day, Year) | 1911 | 9. Birthplace (State or Foreign (Month, Day, Year) | 1911 | 9. Birthplace (Month, Day, Year) | 1911 | 9. Birthplace (Month, Day, Year) | 1911 | 9. Birthplace (Month, Day, Year) | 1911 | 9. Birthplace (Month, Day, Year) | 1911 | 9. Birthplace (Month, Day, Year) | 1911 | 9. Birthplace (Month, Day, Year) | 1911 | 9. Birthplace (Month, Day, Year) | 1911 | 9. Birthplace (Month, Day, Year) | 1911 | 9. Birthplace (Month, Day, Year) | 1911 | 9. Birthplace (Month, Day, Year) | 1911 | 9. Birthplace (Month, Day, Year) | 1911 | 9. Birthplace (Month, Day, Year) | 1911 | 9. Birthplace (Month, Day, Year) | 1911 | 9. Birthplace (Month, Day, Year) | 1911 | 9. Birthplace (Month, Day, Year) | 1911 | 9. Birthplace (Month, Day, Year) | 1911 | 9. Birthplace (Month, Day, Year) | 1911 | 9. Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1**X**M 2□ F 216-03-9141 94 Yrs September 15, Director Maryland Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow 1X Yes 2 No Director Maryland Calvert St. Leonard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4290 William Whart Road 20676 238 United States Funeral Hems 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. e filed within 72 hours after il Hygiene. other then "natural", or ite 1 ☐ Yes 2 🗶 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Farmer Farming 8th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fite Department of Health and Mental Hy important: if item 27 is marked oth any Injury or other traumetic event Be Henry Johnson Annie Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edna G. Johnson-Mason (Cousin) 106 Central Drive; Prince Frederick, Maryland 20678 20b. Place of Disposition (Name of 20a. Method of Disposition
1 █ Burial 2 □ Cremation 3 □ Removal from State Date 20c. Location - City or Town, State Brooks United Methodist April 1, 2006 4 Donation 5 Other (Specify) St.Leonard, Maryland Church Cemetery 22. Name and Address of Facility.
W. Wesley Chavis III Funeral Services, Inc.
1722 North Capitol Street, N.W.; Wash.D.C. 20001 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on_each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner attending physicism and for use as the burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the at d be detached for 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ZNo 1 Yes Division of Vital or Attending Physicisn: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 | Inpatient Other Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 2 ER/Outpatient 3 DOA After thi funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pendina death. 1 Tyes 2 No investigation Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after of To the Funeral Direct 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0027189 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZAHIR YOUSA WALDORF MD 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

APR 0 6 2006

B2. Registrar's Signature

			1 - For State of Maryland / Departme Certifica	nt of Health and Me ate of Death	ntal Hygie	6.000	12943
			Decedent's Name (First, Middle, Last)	2	. Date of Death Month	Day Year	3. Time of Death
н	Physici /Medio		Bruce George Jenkins	Į.		15 2006	3:30 P.M
	Examir		4a. Facility Name (If not institution, give street and number) 4b. City	y, Town, or Location of Death		4c. County of Death	
	*		233 W. Liberty Street	0akland		Garrett	
	Funeral		1 M 2 F Yrs Months	s Days Hours Min.	. Date of Birth (Month, Day, Y	ear) Co	nplace (State or Foreign untry)
Ц,	Director		217-09-0205 93 Yrs.		Feb. 24.	1913 Mar	yland
	/land low		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Man a-f sh ilied	to	MD Garrett Oakland				1X☐Yes 2☐No
	in the or 28;	Director	10e. Street and Number 10f. 2	ip Code	10g	. Citizen of What Co	untry?
	23e c		233 W. Liberty Street	21550		United S	tates
	r dea	Funeral	Armed Forces? If Yes, sp	edent of Hispanic Origin? (Speci ecify Cuban, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Ame Black, White	
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates: WIJTT	2 ✓ No Specify:		Specify:	• •
21215-0036	thin 72 hours after death with the Maryland e. an "naturel", or Items 23e or 28a-f show Medical Examiner must be notified at			sual Occupation	16	b. Kind of Business/l	ite
15	n "na	plet	(Specify only highest grade completed) (Give kind of wild life. DO NOT Elementary/Secondary (0-12) College (1-4or 5+)	vork done during most of working		b. Tana or Daomboo.	ndony
212	wig ta	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 5+ Principal	/ Superintende	ent	Public Sc	hools
	be filed ital Hygi od other event, I	BeC		18. Mother's Name (First, Middle, Ma.	iden Sumame)	
/lai	should b ind Ments s marked umatic e	10 E		Mary	Smearma	n	
Maryland			19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addre	ss (Street and Number or Rural F	Route Number, C	ity or Town, State, Z	ip Code)
	ss 1 and 2 of Health item 27 I			iberty Street,			
Baltimore,	0 0		20a. Method of Disposition 1	other place)	20	c. Location - City or	lown, State
tim	t. Pag rtment rtent: I			rial Gardens 4/1			
Bal	permit. Pag Department Importent: I eny injury o			and Address of Facility Burd			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mo			_Oakland,	
J.	WE		shock, or heart failure. List only one cause on each line. Immediate Cause (Final		services	,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a	dial : Mar	CTOR		4485
В	Examiner		Due to (of as a consequencem).	Aisenie			12 1.15
		ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a construence of):	acom		-	10,415
	cuted id ansit	Examine	causé. Enter Underlying Cause (Disease or injury that initiated events				years
o,	an an rrial-tr		resulting in death) Last Due to for as a consequence of):				1
8760,	death certificate be executed to attending physician and of for use as the buriat-transit	dlcal	d				
9	death certifica attending pl	Med	IF FEMALE:		· · · · ·		
Box	ath ce	Physician/Me	23b. Was decedent pregnant in the past 12 months?			23d. Date of delife Month	very Day Year
	the a	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (state of the state of the	specify)			
P.O.	that the ded by the detached		Part II. Other significant conditions contributing to death but not resulting in the underlying	çause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
ds,	Se Go	d by	Colon caucop - 1999 diet control	ed dialetes	1 ☐ Yes	2 No 3 Pro	babiy 4 Unknown
COL	- 40	ompleted			24a. Was an	24h Were au	opsy findings available
Be	The law ate has b page 2 si	dmo			autopsy performe	prior to death?	ompletion of cause of
Vital Records	icien: Th certificate ector, pag	e C	25. Was case referred to medical	26. Place of Death (No 1 □ Yes	2 No
>	S S =	OB	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 I	Other		e 6 Other (Spec	ity)
10		on: T	27. Manner of Death 28a. Date of Injury 28b. Time of		d. Tescribe how		.,,
Ö	Attending In death. ector: After by the funer	atlo	I Deciding 5 Ferring	1 ☐ Yes 2 ☐ No			
Division	or Attence after death Director:	Certificat	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)	ory, office 28	f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	itel or irs afte rel Dir led in						
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	ical	29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation	d at the time, date and place, and on, in my opinion, death occurred	d due to the caus at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the within 24	Medic	one) and manner stated. 29b. Signature and title of certifier 2	9c. License number		Date signed (Month	
1	Twill S		Mayaros 1 dry				
,	Allia		30. Name and ad tess of person who completed cause of death (Item 23a) (Type, Print)	D26650		-11-2	CE
	Sall		30. Name and ad ters of person who completed cause of death (Item 23a) (Type, Print)	ighulay on l	cland.	4-17-20 MD 215	50
	Sta	te	31. Date lied (Month, Day, Year) 32. Registrar's Signature	J. way	,		
	Registi		APR 1 8 2006				

			For State Registrar	State o	f Marylan		artment rtificate			ind M	lental Hyg	iene	6	12944	
	Physici /Medic Examin	al	Decedent's Name (First, Middle,	J	AFF	-	4b. City. T	own or	Location o	f Death	2. Date of Deal Month APRIL		Year 006	3. Time of Death	1
	Funeral	er		3. Sex	Washing 7. Age (In yrs. 78		If Under 1	1 Year	Location of	24 Hrs.	8. Date of Birth	Mon	tgome		 n
	Director		471-22-9948 Usual Residence of Decedent	1□ M 2X1F	/8	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day Nov.30	, Year) 927	S€°	lace (State or Foreign Paul, MN	_
	Marylan B-f show ilied at	tor	MD 10b. County Montgo	mery		y, Town or Lo							1	0d. Inside City Limits 1 🛱 Yes 2 🗌 No	
	h with the	Funeral Director	10e. Street and Number 6121 Montrose	Rd.			10f. Zîp (Code 208	52		1	0g. Citizen of U.S	What Coun	try?	
5-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show the Madical Examinat must be notified at	þ	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Fo	2 ∑No ve	1	Was Decede If Yes, speci 1 ☐ Yes 2	_	spanic Origin, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)		ce - Americ ck, White,		
N-61212	a within 72 ho piene. r than "naturi the Medical I	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+)	(Give	dent's Usual kind of work DO NOT use emaker	k done d e retired)	tion uring most	of worki	ng	16b. Kind of B	usiness/Ind	,	
Maryland	should be filed nd Mental Hygi rmarked othar umatic event, II	To Be C	17. Father's Name (First, Middle, Lo Nathan	s. Berko	vitz				18. Mothe	r's Name Anna	(First, Middle, Fid		ne)		
	and 2 sho ealth and I m 27 Is ma		19a. Informant's Name/Relationshi Bruce Jaffe /			19b. Mailie 1162	ng Address 8 Log	(Street a	^{nd Numbe} p Tra	ir or Rura	Ellicot	t City or Town, t City,	State, Zîp MD	^{Code)} 21042	
altımore,	Pages 1 ment of H ant: If ital		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Spa 21. Signature of Fundral / rvice Li	ecify)		22	Mem . 2. Name and	Gar Gar Addres	den A	pr.	9,2006 rchinsk	y Hebre	Hurch	n, VA meral Home	
n			23a. Part1. Enter the disease, or 6 shock, or heart failure. List o	omplications that only one cause on e	caused the deat	h. Do not ent	er the mode	of dying	, such as	cardiac c	, Washi		DC 20	Approximate Interval Between Onset and Death	
8/60,	/Medical Examiner superior sup	dical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a conseq (or as a conseq (or as a conseq	uence of):	EF	Flo	1910	ON	/				
O. Box 62	The law requires that the death certificate be executed te has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1 ☐ Live t	tcome of pregna birth 2 Peta nant at time of d own	Ideath 3[Ectopic pre						te of delive	ry Day Year	
rds, P.	quires that t n signed by uld be deta	þ	Part II. Other significant condition	s contributing to d	eath but not res	ulting in the u	nderlying ca	use give	n in Part I.		23e. Did tol	1/		e cause of death?	ı
Vital Records,		Completed									24a. Was a autops perforr	ned?	prior to con death?	osy findings available appletion of cause of 202 No	}
ot VII	Physiciar this certif ral directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No			ER/Outpatier			r: 4 Nu	rsing Hor	n (Check only on me 5 ☐ Reside	ence 6 □Oth)	_
Division	ling I	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no	ation	of Injury th, Day Year)	28b. Time o Injury	М		at ? 'es 2 🗆 l	No	28d. Describe ho				
<u>></u>	pital or Attano ours after death leral Director: filled in by the f		4 Homicide determin	ned 286. Place build	of Injury - At he ing, etc. (Specif	y) 					28f. Location (St City or Town	n, State)			_
	To the Hospital within 24 hours a To the Funeral completely filled	ledical	(Check only 2 Medical E one)	Physician: To the xaminer: On the b and man	best of my kno easis of examina ner stated.	wledge, deatl ition and/or in	vestigation,	in my op	inion, deat	d place, a h occurr	ed at the time, d	ate and place,	and due to	the cause(s)	_
	Mwith To Con	Σ	29b. Signature and title of certifier	no!	Kolon	eug,	M.D.		354		5 /	9d. Date signer			
_	<i>-</i>		30. Name and address of person w	no completed cause	OAD, 1	WUE		Bar	bara	Kala 4D	ZOS:	52			
#	Sta Registr	-	31. Date filed (Month, Day, Year) APR 1 1	2006	egistrar's Signa	H. Age	ali								

			1 - For State Registrar	State of M	larylan		artment of I				iene) (6	12945
÷.		; #	1. Decedent's Name (First, Middle, La	ist)						2. Date of Death Month	Day	Year	3. Time of Death
	Physicia /Medic	_	Anne	Marie	-	Joyce				April 6			6:53 a ^M
	Examin	_	4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town,	or Location of	of Death	•	4c. County	of Death	
		,	10330 Deer Trail	l Drive			Di	unkirk			Ca	lver	t
¥-,	Funeral		,		ge (In yrs.	last birthday)	If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	9. Birth	place (State or Foreign ntry)
	Director		107-20-5508	1□M 2\\ F	75	Yrs.				Mar. 30	, 1931	Peni	nśylvania
1	2		Usual Residence of Decedent 10a, State 10b, County		10c Cit	y, Town or Lo	cation						10d, Inside City Limits
	sho of at	۱	,		100.00	y, 10 mil 01 20							1 ☐ Yes 21☑ No
	or 28a-f show	Director	MD Calver	ct				unkirk			0.000		
	o a	급	10e. Street and Number				10f. Zip Code				0g. Citizen of ₩		ntry ?
-	8 23	Funerai	10330 Deer Trai		· Francis III	0 40.1		0754			US.		
1	itan i	nu	11. Marital Status 1 ☐ Never Married 2 ☒ Marned	12. Was Decedent Armed Forces	?	.5.	Was Decedent of I f Yes, specify Cub	an, Mexican	n, Puerto R	lican, etc.)		k, White,	can Indian, , etc.
	7.7 nous aren dearn win ine marye "natural", or itama 23a or 28a-1 shoi polical Examili winnast be molified at	by	3 Widowed 4 Divorced	1 ∏Yes 2 X If Yes, Give X Year or Dates:	140		1 ☐ Yes 2 🔀 No	Specify:			Specify		white
3	tura Ent E		15. Decedent's E			16a, Dece	dent's Usual Occu	pation			16b. Kind of Bu		
	n "n feedis	Completed	(Specify only highest gra	ade completed)	6. 3	(Give	kind of work done DO NOT use retire	during mos	t of working	g			
1	tha	E o	Elementary/Secondary (0-12)	College (1-4or	5+)	sec	cretary				Univer	sitv	of MD
3 4	Hyg othe	0	17. Father's Name (First, Middle, Last)				18. Mothe	er's Name	(First, Middle, N			
5	strough the weather in the manyanger of	To B	Edgar Jose	eph Dr	rish			Kat	herir	ne			Kina
<u> </u>	of Health and Mental Hygiene If item 27 is marked other than "nature or other traumatic event, the Mudical		19a. Informant's Name/Relationship (19b. Mailir	ng Address (Stree				City or Town,	State, Zij	p Code)
	27 is		John D. Joyce, 1	husband		1033	30 Deer 5	Trail	Drive	e, Dunki	irk, MD	207	54
5	it Hei		20a. Method of Disposition			Place of Dispo	sition (Name of natory or other pla	ice)	Da	ate 2	20c. Location -	City or T	own, State
2	rages I and nent of Health nt: If item 27 iry or other tr		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		9		rial Gard		4/10/	/2006	Dunki	rk,	MD
	FEE		21. Signature of Funeral Service Lice	OS66			. Name and Addr					<u>-</u>	
Š	Depa Impo		William .	R. Gie)	I	Rausch Fi	meral	Home	P.A.	. Owing	s. M	D 20736
	\$ 6.		23a. Part1. Enter the disease, or com	plications that cause	d the death								Approximate Interval Between
	hysician		shock, or heart failure. List only Immediate Cause (Final			n's Dis	20200						Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as			sease						3 years
E	xaminer					,							
*,	3 3	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a conseq	uence of):			-		· · · · · · · · · · · · · · · · · · ·		
	nd ransii	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C									
5	icien and burial-transit	EX	resulting in death) Last	Due to (or as	s a conseq	uence of):							
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	attending pl	an/I	23b. Was decedent pregnant	23c. If yes, outcome 1 Live birth			Ectopic pregnanc	v			23d. Dat		,
	he at	sici	in the past 12 months? 1 ☐ Yes 2 ☒ No	4 ☐ Pregnant a 9 ☐ Unknown	at time of d	eath 5	Other (specify)				Mor	1(1)	Day Year
	ned by the a	Physician/Me	9 Unknown							00 01111			
ń	igned be del	Ď	Part II. Other significant conditions	contributing to death t	but not res	uiting in the ui	nderiying cause gi	ven in Part I.					the cause of death?
5	peen s	ted								1 \ Ye	s 2 XNo	3 Pro	bably 4 Unknown
נ נ	has b	pie								24a. Was an autopsy	/ P	rior to co	opsy findings available ompletion of cause of
		Completed								perform	led? d ⊠No 1	leath?	2 □ No
	certificate	Be	25. Was case referred to medical examiner?							(Check only one			
	his c	၉	1 ☐ Yes 2 🂢 No			ER/Outpatier				e 5 ∏ Reside			fy)
	Wher	on:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury ay Year)	28b. Time of Injury	Wo			8d. Describe ho	w injury occurr	ed	
	tending ringeries. for: After this certific the funeral director.	cat	2 Accident investigatio 3 Suicide 6 Could not b					Yes 2					
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	within 24 hours after death To the Funeral Director: \(\) completely filled in by the f	Mec	29b. Signature and title certifier	and mainler si			29c. Licen	se number		29	d. Date signed	(Month.	Dev. Year)
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	15		30. Name and address & person who					210	Daci	T 7-	ا عادر فود	WD 2	0679
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	Registr	(4)	APR 1	1 2005	Brew	J.K	Courte	9					

			For State Registrar	State of Ma	-	artmen ertificat			nd Me		iene og. No. 0 0 6	12946
	Discontinu		1. Decedent's Name (First, Middle, Last)					2	Date of Deat	-	3. Time of Death
	Physic /Medi		TRENT MANUEL KOP							April 2		5:06 p M
7	Exami	ner	4a. Facility Name (If not institution, give	· ·				Location of			4c. County of Death	
			12001 Pleasant P: 5. Social Security Number 6. Se	4	(In yrs. last birthday		chell 1 Year	ville		. Date of Birth	Prince G	eorge's
н	Funeral Director			ÅM 2□F	41 Yrs.	Months	Days	Hours	Min.	Month, Day, June 8,	Year) Cor	nington, DC
	P .		Usual Residence of Decedent									
	be filed within 72 hours after death with the Maryland lat Hygiene. d other then "naturel", or iteme 23a or 28a-f show event, the Medical Evarrings must be notified at	5	10a. State 10b. County		10c. City, Town or L	ocation						10d. Inside City Limits 1 X Yes 2 □ No
	the M	Director	Maryland Prince Ge	eorge's	Cheverly	104 7:-	Cada				O Citizen of Miles Co	
	with with	٦				10f. Zip					Og. Citizen of What Co	untry !
	ne 23	Funeral	3101 Laure1 Avenu	12. Was Decedent Ex	ver in U.S. 13.		785 dent of His	spanic Orig	in? (Specif	y Yes or No-	U.S.A.	ican Indian.
မှ	or ite	핕	1 ☑ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 📉 No		If Yes, spec	offy Cuban	n, Mexican,	Puerto Rio	can, etc.)	Black, White	
Ö	rei', c	1 by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2K No	Specify:			Specify: Wh:	ite
Maryland 21215-0036	72 h	Completed	15. Decedent's Edu (Specify only highest grad	cation le <i>completed)</i>	16a. Dece (Giv	edent's Usua kind of wo DO NOT us	al Occupa rk done di	tion u <i>ring</i> most	of working		16b. Kind of Business/I	ndustry
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2	filed Hygie Hygie ther I		17. Father's Name (First, Middle, Last)		Ете	ctric:		18. Mother	's Name /F		Building I Maiden Surname)	ndustry
aŭ	2 should be filled within and Mental Hygiene. Is marked other then "raumatic event, the Men	To Be	Thomas Koplock				į			Ellen K		
ary	shour nd M mar	-	19a. Informant's Name/Relationship (7)	rpe, Print)	19b. Mail	ing Address	(Street a				City or Town, State, Z.	ip Code)
	and 2 salth a n 27 is		Marcia E. Porteri	field - Mot							hellville,	
ore,	of He of He litem r oth		20a. Method of Disposition	Compared from State	20b. Place of Disp cemetery, cre	osition (Nari	ne of ther place	,	Date	9 2	20c. Location - City or 1	own, State
Ë	Pages ment of I ant: If its ury or o		1 ☐ Burial 2 \(\) Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State	Metropolit				/5/20		Alexandria,	
Baltimore,	permit. Pages 1 and 2 should bepertment of Health and Men important: if item 27 is marke any injury or other traumatic.		21. Signature of Funeral Service Licens	99							neral Home	
ш	6 5 2 0 3		Valual / flow the	100 MC							sville, MD	20781
	Physician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on each line	ne death. Do not er atic Cance		e of dying	i, such as c	ardiac or ri	espiratory arre	st,	Approximate Interval Between Onset and Death 5 Months
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):							
П		- O	Sequentially list conditions,	Due to for as a	consequence of)							
	uted 1 nnsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,							
Ć.	exection and ital-tra		that initiated events resulting in death) Last	Due to (or as a	consequence of):							
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9	death certificate be executed e attending physicien and of for use as the burial-transit	Med	IF FEMALE:			-						
Вох	ath certific attending p for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 Live birth 2	Fetal death 3	⊒Ectopic pr	egnancy				23d. Date of deliver Month	very Day Year
<u>o</u> .	the a	/slc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∏Pregnant at tii 9☐ Unknown	me of death 5	Other (sp	ecity)				World	Day
<u>α</u>	requires that the leen signed by th hould be detache		Part II. Other significant conditions con	ntributing to death but	not resulting in the	inderlying c	ause giver	n in Part I.		23e. Did tob	acco use contribute to	the cause of death?
ds,	sign d be	d by	-0.	• • • • • • • • • • • • • • • • • • • •	,		g				s 2 □ No 3 K Pro	
Ö	w requir been si should	Completed								24a. Whas an	24h Wara aut	angu findinga ayaylahla
æ	The law ate hes b page 2 st	Ĕ							_	autopsy	prior to co led? death?	opsy findings available ompletion of cause of
of Vital Records,	an: T tificat tor, pë	0	25. Was case referred to medical					26 Place	of Death (C	1 ☐ Yes 2		^{2□No} s Residence
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<u>Si</u>	Attending ir death. ector: After by the fune	atlc	2 Accident investigation	,		М		es 2 🗌 N	0			
Division	of or Attend after death Director: A	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	y - At home, farm, st (Specify)	reet, factory	, office		28f	Location (Str. City or Town,	eet and Number or Rui State)	al Route Number,
	urs al		200 O 111 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1									
	Hospitel or 24 hours afte Funerei Dir stely filled in t	Medical	29a. Certifier 1 Certifying Physical Check only 2 Medical Examination	sician: To the best of ner: On the basis of e and manner state	xamination and/or in	n occurred evestigation,	at the time in my opi	e, date and inion, death	place, and occurred	due to the ca at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the Hos within 24 h To the Fur completely	Mec	29b. Signature and title of certifier	and mainler state		290	. License	number		29	d. Date signed (Month)	Day, Year)
	F 3 ⊢ ŏ) In the	(, 6	est							
0	(1)		30. Name and address of person who co	impleted cause of dea	ath (Item 23a) (Type		D003	8578 t Fen	ton	M D	4/4/200	Jb
K	(P)		22 South Green St	•		-			∟ ∪11,	ri•D•		
	[©] Sta		31. Date filed (Month, Day, Year)	2. Registrar	s Signature	_					· · · · · · · · · · · · · · · · · · ·	
	Registr	ar	APR 0 6 2006	Reader .	K fin	50						

			1 - For Stata Ragistrar	State of Ma	ryland		artmen tificat			and M		giene	6	12947
	Physici	an	1. Decedent's Name (First, Middle, Last)								2. Date of Dea Month		Year	3. Time of Death
	Physici /Medi		Lucy Elle	n Ko	och						April	9, ^{Day} 2006		9:28 a M
	Examir		4a. Facility Name (If not institution, give s	treet and number)			4b. City,	Town, or	Location o	f Death		4c. County	of Death	
10		20	Calvert Memorial						rede				alve	
* 1	Funeral Director		5. Social Security Number 6. Sex 578-40-1421	м 21XF 7. Age	(In yrs. Ia 76	st birthday) Yrs.	If Under Months	1 Year Days	If Under : Hours	Min.	8. Date of Birtl (Month, Day Jan 10	1930		place (State or Foreign ntry) ginia
	land land		10a. State 10b. County		10c. City,	Town or Lo	cation							10d, Inside City Limits
	Mary -t-h	ō	MD Anne Arun	del l	F	Rose H	aven							1 ☐ Yes 2 XNo
	1 the	rec	10e. Street and Number	3.02			10f. Zip	Code				10g. Citizen of V	What Cou	ntry?
	A with	DI	628 Alabama Ave	nue				2071	14			U.	S.A.	
	deat	Funeral Director		2. Was Decedent E Armed Forces?	ver in U.S	. 13. V	Vas Deced			gin? (Spec	cify Yes or No- Rican, etc.)	14. Rac	e - Ameri	can Indian,
9	after or Its	F	1 Never Married 2 Married	1 Yes 2 XN	0	1				, rueno r	rican, etc.)		k, White,	etc.
9	72 hours after death with the Maryland naturel', or Itama 23a or 28a-1 ehow ulcal Examiner must be notified at	d by	3 ☐ Widowed 4 X Divorced	Year or Dates:			☐ Yes	X	Specify:			Specify	wh:	ite
21215-0036	"nati	Completed	15. Decedent's Educ (Specify only highest grade			16a. Deced (Give	kind of woi	rk done a	urina most	of workin	ng .	16b. Kind of Bu	ısiness/In	dustry
12	withir ane. then	E G	Elementary/Secondary (0-12)	College (1-4or 5+	-)		00 NOT us)			,		
	Hygie ther ther		17. Father's Name (First, Middle, Last)			Da	rtenc	ær	18. Mothe	r's Name	(First Middle	resta Maiden Suman		
an	Aental Aental rked o	To Be	Ottis Hawki:	ns						œrta		cown	,	
2	shound Mind	-	19a. Informant's Name/Relationship (Typ	e, Print)		19b. Mailin	g Address	(Street a				r, City or Town,	State, Zit	Code)
	permit. Pages 1 and 2 should be tited within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 ie marked other then "naturel", or itama 23a or 28a-f ehow any injury or other traumatic event, the Macical Examiner must be notified at ance.		Jessie Pennell, s	ister			_					MD 207		ŕ
Baltimore,	of Hear		20a. Method of Disposition		20b. Pla	ice of Dispos metery, crem					ate	20c. Location -		own, State
Ĕ	Page nent c int: if		1 ☐ Burial 2 🂢 Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State						04-1	11-06	Alexand	ria.	VA
alti	permit. Departr Imports eny inju	-	21 Signature of Funeral Service Licen #	9	- STREET				s of Facility					711
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8760,	Physician /Medical Examiner physician and physician and the priniple francial francial francial francial francial francial francial francial francial francial francial francial francial francial francial francial francia	cai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	Due to (or as a	Conseque	ASI	ss icles L-113	-						Onset and Death
P.O. Box 68	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Yes	c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal	death 3 🗌	Ectopic pro Other (sp					23d. Dat Moi	e of delive	ery Day Year
Division of Vital Records, P	w requires that been signed b should be deta	by	Part II. Other significant conditions conf	1.4	-		derlying ca	ause give	n in Part I.			bacco use conti		he cause of death?
00	w req	Completed			,						24a. Was a	n 24h V	Vere auto	ppsy findings available
Be	The tay te has age 2	E O									autops perfori	med?	rior to co leath?	impletion of cause of
ta	ician: Th certificate rector, pag	0	25. Was case referred to medical						26 Place	of Death	Check only or		∐Yes	2110
<u> </u>	Attending Physician: Ir death. ector: After this certifics by the funeral director.	To B	examiner? 1 ☐ Yes 2 ☐ No Ho	spital: 1 Inpatien	t 2 🗆 El	R/Outpatient	3 🗆 DO	A Othe				ence 6 Othe	er (Specif	·v)
0	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day	Year) 2	8b. Time of	2	8c. Injury Work				w injury occurr		
sio	ttendii death. :tor: A : the fu	catic	2 Accident investigation				М		es 2□N	10				
<u>Š</u>	를 를 들	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - At hom (Specify)	ne, farm, stre	et, factory	, office		28	8f. Location (Si City or Town		er or Rura	al Route Number,
_	ospital hours a uneral ily filled		29a. Certifier 1 Certifying Physi	cian: To the best of	my knowl	ledge death	oncurred :	at the ten	o data ana	t place or	ad due to the a			
	24 h	edicai	(Check only 2 Medical Examin one)	er: On the basis of e	examinatio	on and/or inv	estigation,	in my op	inion, deat	h occurre	d at the time, d	ate and place, a	ind due to	the cause(s)
	To the Hospital within 24 hours a To the Funeral completely filled	Me	29b. Signature and title of certifier				29c	License	number		2	9d. Date signed	(Month,	Day, Year)
)) / M/M	1				000	6194	17		4/10	106	
	7		30. Name and address of person who con	npleted ause of dea	ath (Item 2	23а) (Туре, Р			DI 1º	1.1	-	1	00	
	1		Manoj Mathur, M.D	., 110 Hos	spita	l Rd.	Suit	e 30	5, Pr	rince	Freder	cick, M	206	78
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 1	32. Registra	s Signatu	J.	doe	K.			_			

		•	For State Registrar	State of	Marylan		artment of Hertificate of L		Mental Hyg	jiene leg. No.	6	2948
			Decedent's Name (First, Middle, La	st)		-	-		2. Date of Dea Month	th Day	Year	3. Time of Death
	Physicia		Charles A. Kr	aft.					April	1 1	2006	2:20 A M
	/Medic Examin		4a. Facility Name (If not institution, give		nber)		4b. City, Town, or	Location of De		4c. Coun	ty of Death	<u> </u>
	CXAIIIII	eı	225 Maryland Ave	1110			Fdae	ewater		Δη	ne Aru	ındel
	Funeral				7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 H)		place (State or Foreign
	Director		577 05 1251	1 🔀 M 2 🗆 F	88	Yrs.	Months Days	Hours Mi	April	21,191°		nington, DC
			Usual Residence of Decedent									
	ylan how		10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation				1	10d. Inside City Limits
	Mar a-f e	ģ	Maryland Anne i	Arundel		Edgev	vater					1 Tyes 2 No
	h the	ire	10e. Street and Number			15/67	10f. Zip Code			10g. Citizen o	f What Cou	ntry?
	h wit	by Funeral Director	225 Maryland Aver	nue			2	21037			USA	
	deat	ner	11. Marital Status		dent Ever in U	.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin?	(Specify Yes or No-		ace - Americ	
9	after or ite	T	1 Never Married 2 Married	1 Tes If Yes, Giv	2 🔀 No		1 ☐ Yes 2 🔯 No	Specify:		Spec	T.Tl.	nite
8	rail,		3 Widowed 4 □ Divorced	Year or Da	ates:							
21215-0036	72 hours after death with the Maryland Instural, or Items 23a or 28a-f ehow Josal Exacilinet roust be notified at	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		(Give	dent's Usual Occupa kind of work done of	furing most of w	vorking	16b. Kind of	Business/In	dustry
2	within ene. than "	npi	Elementary/Secondary (0-12)	College (1	-4or 5+)		DO NOT use retired			Rail	beer	
	filed w Hygier other th	S	12			Braker	nan-Conduc		In an a Clima A diedelle			
덜	be file ad oth	Be	17. Father's Name (First, Middle, Las						lame (First, Middle,		arrie)	
<u>K</u>	should to marke umatic	ဥ	Norman Andrew Kra						Mae Dunkl			
Maryland	2 should be and Mental is marked raumatic ev		19a. Informant's Name/Relationship						Rural Route Numbe			
	1 and 2 Health tem 27 other tr		Carol A. Nida/Da	ughter_	1			e Rd. Ed	dgewater,			21037
ore	S to		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 [Removal from	State	cemetery, cre	osition (Name of matory or other plac	1	Date	20c. Location	n - City or in	own, State
Ĕ	Pages nent of I ant: If its arry or o		`4 □Donation 5 □Other (Spec		Ft.	. Linco	oln Cemete	ery 4-!	5–2006	Bren	twood,	MD.
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of Fune al Service Lice	nsee					eorge P. 1 and Rd. E			
	Pnysician /Medical Examiner	er	23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. Due to	aused the deal ach line. As a consecutive of as a consecutive of as a consecutive of a con	quence of):	ter the mode of dyin:	g, such as card	iac or respiratory ar	rest,		Approximate Interval 8-tween Onset and Death
,68760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burral-transit	Medical Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	d	(or as a consec							
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Δ,	w requires that been signed b should be deta	by	Part II. Other significant conditions Divictes w	elletu	, typ	2 2		en in Part I.	\sim	obacco use co ⁄es 2□No		the cause of death? bably 4 □Unknown
of Vital Records,		Completed	chronie of	struct	tive p	ulmor	any dis	easp	24a. Was autop perfo 1 🗆 Yes	rmed?	b. Were autoprior to co death? 1 Yes	opsy findings available ompletion of cause of 2 No
/ita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	II. Neb			Out		Death Check only o	пе		
) t	S S	0	1 ☐ Yes 2√2 No			ER/Outpatie		4 Nursin	g Home 5 X Resid			fy)
	ding Phi h. After thi funeral	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of	Wor		28d. Describe I	now injury occ	currea	
<u>Ö</u>	endii sath. or: A he fu	ati	2 ☐ Accident investigate					Yes 2 □ No				
Division	or Attencafter death Director: in by the	Certification:	3 Suicide 6 Could not 4 Homicide determine	d 200. Place	of Injury - At hing, etc. (Spec	nome, farm, si ify)	treet, factory, office		28f. Location (S City or Tox		mber or Hur	al Route Number,
	rs aft al Di ed in	Cer										
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier Certifying I (Check only one)	aminer: On the b	e best of my kn easis of examin iner stated.	owledge, dea ation and/or i	th occurred at the tirnvestigation, in my o	ne, date and pl pinion, death o	ace, and due to the ccurred at the time,	cause(s) and date and plac	manner as	stated. to the cause(s)
	ro th vithin ro th	Me	29b. Signature and title of certifier)			29c. Licens			29d. Date sig		
	->-0		10.113	2 ren	mo	,	100	0295	7/	04/03	3/20	06
7			30. Name and address of person wh	o completed cau	se of death (Ite	m 23a) (Tvne			ez, M.D.		,	
			2225 Defense Hic			Croft			.C2, FI.D.			
	C+	ate	31. Date filed (Month, Day, Year)	32. F	egistrar's Sign	ature		1.154				
	Regist		APR 05	2006	Com	A A						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 2006 Darlene April 7:21 Lewis /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 ☐ M 2 🖾 F 30 Director 217-27-6442 Yrs. 24, 1975 Washington, DC Nov. Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show treumatic event, the Medical Examiner must be nutified a Maryland Prince George MXYes 2 No Directo Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 7736 Loudon Drive 20744 iteme 23a United States Peges 1 and 2 should be filed within 72 hours after death Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐ Yes 2XXXNo If Yes, Give Year or Dates: 1X Never Married 2 Married Baltimore, Maryland 21215-0036 ö þ 1 ☐ Yes 21 No Specify. Specify: Black 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) al Hygiene. College (1-4or 5+) 12 Telemarketer Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mental and Mental Alfred D. Lewis Gloradine Cheek ္ရ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 other tr Alfred D. Lewis/Father 7736 Loudon Dr.; Ft. Washington, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of himportant: if its any injury or of once. 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park April 7, 2006 Landover, Md. 21. Signature of Funeral Service 22. Name and Address of Facility Pope Funeral Homes 5538 Marlboro Pike Forestville, MD. 20747 23a. Part1. Enter the disease, occomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) UTa ratory /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed Preumonia 0 that initiated events resulting in death) Last Due to (or as a cons P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death signed by the a 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No Completed 1 🗆 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificete has l lirector, page 2 s autopsy performed? Yes 2 No 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: After this certification funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one 28 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00060100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 831 University Blvd. East, Suite 27 Silver Spring, Md. 20903 MIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 7 2006 Registrar

			1 - For State Registrar	State of Ma		partmen ertificat			nd Mei		iene	6	1295	0
18	Physici	an	Decedent's Name (First, Middle, Last, John Chamberlin	Long Ji	•				1	Date of Deat Month	Day	Year	3. Time of	
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	- •	4b. City,	Town, or	Location of D		pril 3,	2006 4c. Coun Montg	ty of Death	11:55	P
	Funeral		Wilson Health Care C 5. Social Security Number 6. Se:	7. Age	(In yrs. last birthda	y) If Under		If Under 24		Date of Birth			place (State or ntry)	r Foreign
	Director		370 22 7311	M 2□ F	83 Yrs.	Months	Days	Hours	Min. Fel	(Month, Day, b. 4, 19			ington,]	
	/land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or								10d. Inside Cit	
	B Man	ctor	Maryland Montgomery		Gaithers	burg							1 🗌 Yes 2	XXX No
	with th	Director	10e. Street and Number 301 Russell Avenue			10f. Zip	Code 20877	,		1	og. Citizen of USA		ntry?	
	Jeath The 23	Funerai		12. Was Decedent E	ver in U.S. 1	3. Was Dece			? (Specify	v Yes or No-		ace - Ameri	can Indian.	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show simportant: if item 27 is marked other than "natural", or items 23a or 28a-1 show stry injury or other traumatic avent, it a Mucical Exertical mail to natified at once.	þ	1 Never Married 2 Married	Armed Forces? ★★ Yes 2 □ N If Yes, Give Year or Dates:	. WII	If Yes, spec		spanic Origin n, Mexican, P Specify:	uerto Ric	an, etc.)	BI	ack, White, White		
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д 2	al Hygie other	BeC	17. Father's Name (First, Middle, Last)							irst, Middle, A				
ylaı	2 should be and Mental I is marked or raumatic sva	To	John Chamberlin Lon					Louise						
Maryland 21215-0036	d 2 sh th and th and 17 is m traum		19a. Informant's Name/Relationship (Ty Thomas J. Long / Son	pe, Print)	1	. Va				oute Number,				
re,	es 1 and of Health fitem 27 r other tr		20a. Method of Disposition		20b. Place of Dis		ne of		Date	sville,	PELLY LAT 20c. Location			_
imo	Pages nent of I snt: If its ury or o		1 ☑ Donation 5 ☐ Other (Specify)	emoval from State	Gate of He			. 1	ril 7.	2006_	Wheater	i. Marry	land	
Baltimore,	permit. Pag Department Important: sny injury c once.		21. Signature of Funeral Service License	90		00 Name	at A state of	4 EIPA-		P. Kal Hill, M				
**	402 * 4		23a Part 1. Enter the disease, or compli	cations that caused	the death. Do not a							2074	5 Approximate	
	Physician		Immediate Cause (Final	P C	PIDAT	200	C ,	FAIL					Interval Betw Onset and D	veen
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	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a		1126	_	DIS	FA	SF				
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8760,	icate be executed physicien and s the burial-transit	dica		l										
Вох 6	eath certific attending p	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome o	f pregnancy						23d D	ate of deliv	arv	
	that the death cer ed by the attendin detached for use	siciai	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown		3 □Ectopic pr 5 □ Other (sp						lonth	,	ear
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Division of Vital Records,	: The law cate has b page 2 sl	Completed							-	24a. Was ar autopsy perform 1 Yes 2	/	Were auto prior to co death? 1 \(\text{Yes}	psy findings a mpletion of ca 2 No	vailable use of
Vita Vita	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:			Othe			heck only one				
ō	Attending Physician: r death. sctor: After this certific by the funeral director.	n: To	27. Manner of Death	28a. Date of Injury	28b. Time		8c. Injury Work	4 Nursir		5 Reside			y)	
ion	ttending F death. ctor: After y the funer	atio	1 Natural 5 Pending investigation	(Month, Day	Year) Infun	М		? 'es 2 □ No						
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	To the Hospital or Attending Physician: The la within 24 bours after death. within 24 bours after death. go the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai C	29a Certifier (Check only one) 2 Medical Examin	ner: On the basis of e and manner state	examination and/or	ath showed investigation,	at the tim in my op	a, date and pl inion, death o	lace, and occurred a	due to the ca at the time, da	te and place	and due to	tated. o the cause(s)	
	To the	Me	29b. Signature and title of certifier	,			License			29	d. Date sign			
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	The		30. Name and address of person who come RL HW YEA 31. Date filed (Month, Day, Year) ADD 0.6. 2006	mpleted cause of de	7801 6t	EORG-	IA	AVE	2, S	GUITE	22	7	SILVE	R
	Sta Registr	te ar	APR 0 6 2006	32. Registrar	's Signature				SPR	1106	, MD	20	902	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 04:30AM 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 4 8. Date of Birth (Month, Day, Year) orchester (reneral hester 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Days 13-24 -1505 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Itama 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MD Jorchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 216 arr U 46 25 11. Marital Status 1/e Koad Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify: Completed by 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry s 1 and 2 should be filed within if Health and Mental Hygiene, item 27 le marked other then Elementary/Secondary (0-12) College (1-4or 5+) Board of Education Service Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Albert Robinson 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD. 21677 4619-Harrisville Rd. Woolford nery 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - Oty or Town, State permit. Pages 1
Department of H
Importent: If itel
any Injury or ott 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/12/06 Cambridge, Maryland Brisco MeMorial Park! ^ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HENRY FUNERAL HOME, Henry tanelle 510 Washington St. Cambridge MD. 21613 23a. Part 1 Inter the disease, or complications that caused the ceath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each live. Approximate Interval Between Onset and Death Immediate Cause (Final 10612stoma Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Examiner the attending physicien and hed for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 201010076 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐Unknown Completed yolrat 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 Yes 2/No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 2 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of De th 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No in by the Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours after To the Funerel Dire fSL Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month/ Day, Year) 5 2006 D00618 22 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) Byrn St. Cambridge 21613 MU 1

State Registrar 31. Date filed (Month

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6 2006

32. Redistrar's Signature

			For State Ragistrar		State of	Maryland		artmen rtificate		ealth and N Death	Mental Hy	gien Reg. N	000	129	52
			1. Decedent's Name (Firs	t, Middle, Las	st)						2. Date of D Month		ay Ye		of Death
	Physici /Medic		Ed	ward F	. Lathro	р						8,20		5:1.	5A M
	Examin		4a. Facility Name (If not in	stitution, give	street and numi	oer)	-	4b. City,	Town, or l	ocation of Death		4	c. County of E		
			Anne Arunde	1 Medi	cal Cent	ter			Anna	polis		A	Anne Ar	undel	
G.	Funeral		5. Social Security Number			. Age (In yrs. la	ast birthday)	If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of B	rth	9.	Birthplace (State Country)	a or Foreign
1	Director		040-18-3656	1	X M 2□F	92	Yrs.	Wildiais	Days	Hours Will.	Jan.24	,191	4 F1	orida	
	p ,		Usual Residence of Dece			140.00									01.11.11
	aryla Bhov	<u>_</u>	10a. State 10b.	County		10c. City	, Town or Lo	cation						10d. Inside	
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	or 2	Director	10e. Street and Number					10f. Zip	Code			10g. C	Citizen of What	Country?	
	23a	<u>e</u>	710 American	a Driv					2140			Uni	ted St	ates	
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 ie marked other then "naturel", or Items 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at	Funeral	11. Marital Status		12. Was Deced Armed Ford	es?	S. 13.	Was Deced f Yes, spec	dent of His	panic Origin? (St , Mexican, Puerto	ecify Yes or N Rican, etc.)	0-		merican Indian, /hite, etc.	
36	or it	γFL	1 Never Married 2		1 ∑Yes 2 If Yes, Give	□Nº 194	1-	1 ☐ Yes		Specify:			Specify:		
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O	Pages nent of H int: If ite		20a. Method of Disposition 1 ☐ Burial 2 🛱 Crea	mation 3 □	Removal from Si	ate	metery, cre	natory or o	ther place)					
Ë	. Pa tmen tant: jury		4 Donation 5 0			Ft.				ry 4/10/				, Maryla	
Baltimore,	permit. Pages 1 and 2: Department of Health a Important: If Item 27 ie eny Injury or other trau		21. Signature of Funeral	Service Liceo	9 Kil	tta				of Facility Jo Glouces					
			23a. Part1. Enter the disc shock, or freart failu	ease, or com	plications that car	used the death	. Do not en	er the mod	e of dying,	such as cardiac	or respiratory	arrest,		Approxim Interval B	
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	Examiner		2000			Chu	uic.	Atri	al	tilon	llost	m		W	wnth
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Division	ath. r: Af	atic	1 ☐ Natural 5 ☐ 2 ☐ Accident	Pending investigation			,,	М		es 2□No					
<u>Vis</u>	Atte	ific	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	289. Place o	f Injury - At hor	me, farm, st	eet, factory	, office		28f. Location City or To			Rural Route Nu	umber,
Ō	tel or s aftr el Din	Certification;			Danding	, oto (opecity)	,				Only of 10	, Old	,		
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: Atter this certificate ha completely filled in by the funeral director, page	Medical (29a. Certifier 1 (Check only 2 N	ertifying Ph Jedical Exan	ysician: To the b niner: On the bas and manne	is of examinati	wledge, deat ion and/or in	occurred vestigation,	at the time in my opi	, date and place nion, death occur	and due to the rred at the time	cause(s) and manne nd place, and	r as stated. due to the cause	∌(s)
	o the	Me	29b. Signature and title of	f certifier				290	. License	number		29d. D	ate signed (M	onth, Day, Year,)
	F 5 ⊢ 8		Mar	CS	4444	111			0	083	14	0	4108	1900	6
			30. Name and address of	nerson who	completed cause	of death (Item	23a) /Tuna	Print)		2 4 5	1			1	Λ.
			afono	person vo	SAM	AVER	SW	D	110	5 Defe	msl I	Hal	may	the same	91401
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			For State Registrar	State	of Maryla		artment of H rtificate of I		and M		giene Reg. No.	16	12953
	Physici	an	1. Decedent's Name (First, Mid	ldle, Last)						2. Date of De	aath Day	Year	3. Time of Death
	/Medio	cal	4. E 35. N. 27.		e Virginia I	Llewellyn				04	10	06	12:46 P.M.
	Examir	ner	4a. Fecility Name (If not institut	In A O.L. I	INS NITC	1/.	4b. City, Town, or	DDIA	of Death		4c. Coun	ty of Death	0.41
	Funeral		5. Social Security Number	6. Sex		a. last birthday)	If Under 1 Year	If Under 2		8. Date of Bir (Month, Da	th .	Je G 1 9. Birth	
	Director		218-12-5898	1□M 2X	80	Yrs.	Months Days	Hours	Min.	Novembe	r 20, 1925	Cou	place (State or Foreign Maryland
	and wo		Usual Residence of Decedent 10a. State 10b. Coun	ty	10c. C	City, Town or Lo	ocation					1	10d. Inside City Limits
	Mary Inc.	tor	Maryland	Allegany				Barto	n				1 ☐ Yes 2 No
	or 284	by Funeral Director	10e. Street and Number				10f. Zip Code				10g. Citizen of	What Cou	ntry?
	eth w	rai		7 Meece Stree				21521				USA	
	ter de	-une	11. Marital Status 1 □ Never Married 2 □ Ma	12. Was D Armed	ecedent Ever in U Forces? es 26 No	J.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Orig ın, Mexican,	in? (Spe , Puerto I	cify Yes or No Rican, etc.)	14. Ra	ice - Americ ack, White,	
980	al', or		3 ☑ Widowed 4 □ Divorce	If Yes,	Give or Dates:		1□Yes 2No	Specify:			Speci	ify:	White
2-0	within 72 hours after deeth with the Maryland ene. than "natural", or items 23e or 28e-f ehow fra Madical Examiner must be notified at	Completed	15. Decede (Specify only high	ent's Education	ed)	(Give	dent's Usual Occupa	durina most	of workii	na .	16b. Kind of I	Business/In	dustry
121	within then then	mpi	Elementary/Secondary (0-12		e (1-4or 5+)	life.	DO NOT use retired) omemak				Ho	me
d 2	be filed ital Hygie d other	ပိ	10 17. Father's Name (First, Middle	e, Last)	0	1	110			(First, Middle,	Maiden Suma		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. The Important: If Item 27 is marked other than "natural," or Items 23a or 28a-f show erry injury or other traumatic event, the Medical Examination and be notified at ance.	To Be		William Ed	lgar Likens						lettie Elki		
lar	2 should and Mentile market	·	19a. Informant's Name/Relation			19b. Mailir	ng Address (Street a						
e) Z	1 and Health Bm 27 ther tr		Gary L. 20a. Method of Disposition	lewellyn-Son		Place of Dispo	23029 sition (Name of	Meece S		11.9	ton,Maryl		
nor	Pages nent of h int: if ite ury or of		1 ⊠ Burial 2 □ Cremation			cemetery, crei	matory or other plac View Cemete	1		April 13, 2006	20c. Location		s, Maryland
Baltimore,	permit. P Depertme Importan eny injury		4 □ Donation 5 □ Other 21. Signature of Funeral Service					-	/m: 1.1				•
ä	Depermine Depermine Important ir ponce.		Jus E M	Kenie			2. Name and Addres	8 East	Eichn Main	orn-McK StLonac	oning, ME	21539	ne P.A.
			23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that st only one cause o	at caused the dea on each line.	th. Do not ent	ter the mode of dying	g, such as c	cardiac o	r respiratory a	rrest,		Approximate Interval Between
)	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_ a	laite	ma	ocardi	inc	in	n Jan	clion) .	Onset and Death
	Examiner		rosaling in dodairy	Due									
	LAGITHIE			Due	to (or as a consec	quence of).							
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ox 68760,		dical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	to (or as a consect to (or as a consect to or as a consect to outcome of pregn	quence of):					23d, Da	ate of delive	90V
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06-02403	
Lyons, Tricia	

Please Type or Print in Black Indelible Ink

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Physici		Registrar 1. Decedent's Name (First, Middle,				12	2. Date of Deatl	h		Time of Death
dical Exami		Tricia D. Lyo	ns				Month April 8, 20	Day 06	Year	7:26
7		4a. Facility Name (if not institution, Union Hospital	give street and number)		4b. City, Town, or L Elkton	ocation of Death		4c. Cour Cecil	nty of Death	
Funeral		5 Social Security Number 6	S. Sex 7. Age (In yrs	s. last birthday)	If Under 1 Year	If Under 24Hrs,	8. Date of Birt	h (MM/DD/Y	YYY) 9. Birthpl	lace (State or Foreig
Director		141-62-6835	1 M 2 X F	42 Yrs	Months Days	Hours Min.	02/09	/1964	New	york
		Usual Residence of Decedent					1			
w any		10a. State 10b. County		ty, Town or Locat						od. Inside City Limits Yes 2 X No
/land -f sho once,	ţ		cil	Rising						
Man r 28a	Director	10e. Street and Number	1 24 140		10f. Zip Code	011	10	_	f What Country	7
ith the	_	116 Maple Lea	12. Was Decedent Ever in	11 S 13 Wa	Z / as Decedent of Hisp	911	cify Ves or No.	7	USA Race - Americar	Indian Black
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. 11. If item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at once,	Funeral	1 Never Married 2 X Mar		If Y	es, specify Cuban,				Vhite, etc.	i iliulati, black,
ifter d		3 Widowed 4 Divor	rced If Yes, Give Year or Dates:	1 🗌	Yes 2X No	specify:		Spec	ify:	White
lours a	Completed by	15. Decedent's Education (Specia		16a. Deceder	nt's Usual Decupation	on (Give kind of wo	ork done	16b. Kind o	f 8usiness/Indu	ustry
n 72 h nan "n ical E	Jete	Elementary/Secondary (0-12)	College (1-4 or 5+)	most of	working life. DO NO			- 10		
5-0036 led within 7 Hygiene. other than	E O	17. Father's Name (First, Middle, L	2	Substi	tute Scho	OK TEACH 8.Mother's Name (ic Scho	ols
filed al Hyg	Be C	James Mortelli	·			Joan He		alderi Surria	ine)	
212 uld be Menta marke	To B	19a. Informant's Name/Relationshi		19b. Mailing	g Address (Street			ber, City or	Town, State, Zi	ip Code)
MD d 2 sho lth and n 27 is		John J. Lyons	/Husband	116	Maple Le	ah Drive	. Risin	a Sun	. MD 21	911
re, I l and Healt f item er tra		20a. Method of Disposition 1 X Burial 2 Cremation	20		ition (Name of cem		Date		ion - City or Tox	
Baltimore permit. Pages 1 s Department of H. Important: If it		4 Donation 5 Other Spe			Cemetery	4-1	2-2006	Risi	na Sun.	Maryland
Baltimo permit. Page Department o Important:		21. Signature of Funeral Service L	-			of Facility	0 Hama	D A	5	mor cy courta
m 825.5		Excharg of	. Goodie	7	Name and Address T. Foar 11 S. Que	en Stree	t, Risi	ng Su	n, MD 2	1911
Physician /Medical		23a. Part I. Enter the disease, or confailure. List only one cause of	n each line.	ath. Do not enter t	he mode of dying, s	such as cardiac or	respiratory arre	st, shock, or	r heart	Approximate Interval Between Dnset and
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At .			Due to (or as a consequence	e or):						
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6876 certificate iding phy se as the b	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at time of	doath	etal death 3	Ectopic pregnar	icy	Mont	th Day	Year
Box e death c the atten ed for us	Physician/M	1 Yes 2 No 9 V Unkn	7 0	0eatt1 5 0	ther (Specify)					
ision of Vital Records, P.O. Box 6876. Attending Physician: The law requires that the death certificate rector: After this certificate has been signed by the attending phy by the funeral director. page 2 should be detached for use as the t		Part II. Other significant condition	ons contributing to death but no	ot resulting in the	underlying cause gi	ven in Part I.	23e. Did to	bacco use c	ontribute to the	cause of death?
P. (res that signed be del	d by	Head nepplasm					1 Yes	2 🗸 No	3 Probab	ly 4 Unknown
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e law te has ge 2 s	Completed by						perfor	med?	death?	2 No
of Vital Records, ng Physician: The law requir ther this certificate has been s meral director, page 2 should I		25. Was case referred to medical			26.Place	of Death (Check o			1 🗸 163	2 140
Vita ysicia this ce	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	✓ ER/Dutpatien	3 DOA	Other Mursing	Home 5	Residence	6 Other:	
ing Ph After t funeral	n:T	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of	Injury 28c. Injury	y at Work?	28d. Describe h	ow injury oc	curred	
ion tendireath. tor: /	atio	1 Natural 5 Pendii 2 Accident Invest			1_ Y	es 2 No				
Division tal or Attendin rs after death.	Certification:	3 Suicide 6 Could	not be 28e. Place of Injury - A	t home, farm, stre	et, factory, office bu	uilding, etc.	28f, Location (S or Town, St		ımber or Rural	Route Number, City
Divious pital or hours afte uneral Dir	Ser	4 Homicide determ	nined (Specify)				0, 10,111, 0,	4.07		
# 4 E 5			ysician: To the best of my knowledge: On the basis of examination							
To the within To the comple	Medical	29b. Signature and title of certifier	and manner stated.	,, and or investiga	29c. License		and time, date t			
	2	200. Signature and little of certifier	DAO 1		O.C.N			April 9,	signed (Month, 2006	, vay, rear)
		Carrie	att.	00.	0.0.1			, tptii o,	2000	
5		30. Name and address of person vi	vho completed cause of death (It ssist ant Me dic al Examin	,	n Street, B a lti	more, MD 212	201			
	tate					,				
Regis		31. Date filed (Month, Day, Year) APR 1 1 200	32. Registrar's Sign	Rosele						
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Registrar DHMH 17 Rev 1/2001 OCME 10/2003

ORIGINAL

				Otato	of Marylar	•	tificate					16	12955
	Physicia		Decedent's Name (First, Middle Name Wown o Market Mar	10. 270			-		E	2. Date of Dee	Day	Year	3. Time of Death
No. of London	/Medic Examin		Jerry Wayne Mu 4e Fecility Name (If not institution	` _	u <i>mber</i>)			4b. Ci	ty, Town, or L	April ocation of Death	9, 200 4c. County		2:45 A.M.
45		9	Julia Manor	1.0			William and N	8	gersto			ningto	
	Funeral Director		5. Social Security Number 220-42-5695	6. Sex 1)X M 2□ F	7. Age (In yrs.	. lest birthday) Yrs.	If Under 1 \ Months D		ours Min.	8. Date of Birth (Month, Day			ace (State or Foreign
			Usuel Residence of Decedent 10a. Stete 10b. Count			ity, Town or Lo	nation .			Mar.21,	1947		Virginia
	n the Marylen r 28a-f ahow	ō		, ington		ige r stov						1	0d. Inside City Limits 1 ☐ Yes 21 No
	or 28a	Sirec	10e. Street and Number	ingron	110	iger 310	10f. Zip Co	de	*****		10g. Citizen of	What Coun	try?
	es 23e ment to	erai	17024 Hillsdale		and ant From in 1	10 10 1	217		1- O-1 1-0 (O		USA		an Indian
020	72 hours efter death with the Marylend tatural', or flems 23a or 28a-f ahow fical Examiner must be notified at	by Fur	11. Marital Status 1 □ Never Married 2√√Ma 3 □ Widowed 4 □ Divorce	rried Armed F	2⊠No iive	i	Yes, specify	Cuban, Me	exican, Puerto	pecify Yes or No- Rican, etc.)	Bla	e - Americ ck, White, d White	etc.
21215-0020	E .	Completed	(Specify only high	nt's Educetion est grede completed)	16e. Deced	ent's Usual O kind of work of OO NOT use r	ccupation one during	most of work	ring	16b. Kind of B	usiness/Inc	ustry
212	should be filed within nd Mentel Hygiene. marked other than imatic avent, the M	E O	Elementary/Secondary (0-12)	College	(1-4or 5+)		Equip				Educa	tion	
Maryland	be file ntel Hy and outhe	Be	17. Father's Neme (First, Middle							e (First, Middle,		10)	
Z Z	2 should end Mer s marks sumatic	٩	Cecil Leroy Mu 19a. Informant's Name/Relation			19b. Mailin	a Address (S			ern McCu el Route Numbe		State Zip	Code)
, K	end 2 selth el n 27 la		Penelope S. Mur			17024	4 Hills	dale		Hagers			
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health end Mentel Hygiene, important: if Item 27 la markad other than any injury or other traumatic avent, the Monce.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation		1 State	Place of Dispos cemetery, crem	-		l	Date	20c. Location	•	
altin	nit. Perenti entmer ortant injury	.	4 ☐ Donation 5 ☐ Other (c		M+		Pres.						,Maryland
ä	Depe Impo		y cin 7	C. Shu					USI	oorne Fu ue St.			,MD 21795
	Physician /Medical		23a. Part1. Enter the dispese, c shock, or heart failure. Lis	complications that tonly one cause on		th. Do not ente	er the mode of	dying, suc	ch as cardiac	or respiratory an	rest,	 	Approximate Interval Between Onset and Death
*	Examiner		disease or condition resulting in deeth)	ө	Due to (or as e consequ				ailura		1	
	ted sit	niner		b		ngest	- Je	H	cart	1-ail	WA -		
ó	execu en end riel-trei	Exar	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or es e consequ	uence of):	12		Disa			
68760,	icete be execut physiclen end s the bunel-trer	0	Cause (Disease or injury that initieted events resulting in death) Last	C	Due to (c	or as a consequ	rence of):	- 5	<u> </u>	Dis	euse		
	n certifi anding use es			d				-				i	
O. B	e deeth	Physician/M	Part II. Other significant conditi	ons contributing to d	leath but not res	sulting in the un	derlying caus	e giv <i>e</i> n in l	Part I.	23b. Did to	obacco use co	ntribute to	the cause of death?
, P.O	thet the	y Phy		Obesil	ty					1 🗆 Y	es 2□No	3 Prob	ably 4 Onknown
of Vital Records,	law requires that the death certificate be executed as been signed by the ettending physicien end 2 should be deteched for use as the buriel-trensit	Completed by								24a. Was a perfor		ava	re autopsy findings ilable prior to opletion of cause eath?
<u> </u>	sician: The law s certificate has b director, page 2 s									107	55 2(LINO	1 🗆	Yes 2□ No
X X	Physician: rthis certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2	l FR/Outnatient	3□ DOA	Othor		h <i>(Check only or</i> ome 5 ☐ Resid		or (Specific	
	Phys ral di		27. Menner of Death 1 ☑ Naturel 5 ☐ Pendi	28a. Date	of Injury oth, Dey Year)	28b. Time of Injury		Injury at Work?	2 Hursing Fic	28d. Describe h			/
Division	D 5 8		2 Accident invest	igation		ome form stre	М	1 🗌 Yes	2 🗆 No	28f Location /S	tract and Numi		
>	ttending death. :tor: Atlei / the fune	Cat	3 ☐ Suicide 6 ☐ Could				at tastam, of	lina					
ā	tal or Attending rs efter death. al Diractor: After ed in by the fune	Certificat	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deten	nined 286. Place	ling, etc. (Speci		et, factory, of	fice		City or Town	n, State)	er or Hure	Route Number,
Ö	i Hospital or Attending 24 hours efter death. Funeral Diractor: Aftel etely filled in by the fune	dicai Certification:	4 Homicide determ	nined 289. Plac build place bu	ling, etc. (Special beta best of my knows of examina	(y) owledge, death	occurred at th	ne time. da	te and place,	City or Tow	n, State)	inner as st	ated
Ō	To the Hospital or Attending Physician: The is within 24 hours efter death. To the Funeral Diractor: After this certificate he completely filled in by the funeral director, page	edicai	4 Homicide determined the state of the state	ng Physician: To the Examiner: On the band mar	ling, etc. (Special	(y) owledge, death	occurred at the estigation, in the state of	ne time. da	, death occur	City or Town and due to the c red at the time, d	n, State)	inner as sta and due to	ated. the cause(s)
	To the Hospital or Attending within 24 hours effer death. To the Funeral Director: Affei completely filled in by the fune	edicai	4 Homicide determined to the determined dete	ng Physician: To the Examiner: On the band mar	ling, etc. (Special beta best of my knows of examina	(y) owledge, death	occurred at the estigation, in the state of	ne time, da ny opinion	, death occur	City or Town and due to the c red at the time, d	n, State) ause(s) and malate and place,	inner as sta and due to	ated. the cause(s)
	To the Hospital or Attending within 24 hours effer death. To the Funeral Director: After completely filled in by the fune	Medicai	4 Homicide determined the state of the state	ng Physician: To the Examiner: On the band mar	ling, etc. (Special e best of my kno pasis of examina nner stated.	fy) owledge, death ation and/or inv	occurred at the estigation, in a	ne time, da ny opinion	, death occur	City or Town and due to the c red at the time, d	n, State) ause(s) and malate and place,	anner as stand due to	ated. the cause(s)

DHMH 16 Rev 6/95

	3		1- For Amend Item #8 State Registrar WCHD/SH 4/		aryland / Dep _{FH} <i>Ce</i>	artment of H rtificate of		Mental Hy	giene Reg. No.	16	12956
	Physici	an	1. Decedent's Name (First, Middle, La	st)				2. Date of De	aath	_ Year	3. Time of Death
	/Medi	cal		VIOLA	MAUK	T # 65 T	or Location of Dea	APRIL		900	9:55 AM
1	Examir	ner	4a. Facility Name (If not institution, given 3802 Mills	·			sburg	ıın		y of Death shin	aton
	Funeral		Social Security Number 6. 5	Sex 7. Ag	e (In yrs. last birthday,		If Under 24 Hr.		rth	O Biethe	plane (State of Familia
	Director		203-20-03/3	I □ M 💥 □ F	72 Yrs.	Months Days	riours will	Januai	y 4,20		onio
	land land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation		Januar	y 4, 19.		10d. Inside City Limits
	Mary a-f sh	tor	Maryland Washi	.ngton	Sharps	burg					1 □ Yes 2 火 No
	th the or 284)lrec	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cou	ntry?
	ath w	ral	3802 Mills Ro			217			U.S.		
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items the motified at Application of the first final the motified at Application of the first final the motified at Application of the first final first final first final first final first final first final first final first final first final first final first final first final first final first final first final first final first first final first firs	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No		Specify Yes or No rto Rican, etc.)	Speci	ice - Americack, White, fy: Wh	
21215-0036	72 ho	Completed by	15. Decedent's E (Specify only highest gr		16a. Dece	dent's Usual Occup	oation during most of we	orkina	16b. Kind of E	Business/In	dustry
121	vithin na han	mpfe	Elementary/Secondary (0-12)	College (1-4or 5	5+) life.	kind of work done DO NOT use retire Homem		onang .	Own	Hom	
	filed v Hygie other t	e Co	12 17. Father's Name (First, Middle, Last)		110111011		ame (First, Middle			
lan	ld be ental kad o ic avs	To Be	Forrest	Elvin	Robb	ins	Berti	,	live	,	rtel
Maryland	2 should be filed within and Mental Hygiena. is marked other then sumatic avant, the Mental Health.	-	19a. Informant's Name/Relationship	Type, Print)		ng Address (Street					
	ss 1 and 2 of Health a item 27 is		Gregory A. Ma	uk Son			ark Cour				nia 22601
Baltimore,	Pages 1 nent of H ant: If ites ary or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	-	matory or other pla		Date	20c. Location	•	
Itim	permit. Pag Department Important: I any injury o		* 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice	<u></u>	Manor Chu						Maryland
Ba	permit. Departr Importa any inji		V. R. Roel &	rady	40	2 Name and Addre	Lietam Si	treet, H	agersto	nc. wn, M	
	Physician /Medical		23a. Part1. Enter the disease, or con shock, or heert failure. List only Immediate Cause (Final disease or condition resulting in death)	a Lun	Cancer a consequence of):	ter trie mode or dyli	ng, such as cardia	ac or respiratory a	irrest,		Approximate Interval Battween Onset and Death 33 Months
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	ad isit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):						
8760,	cate be executad physician and the burial-transit	dical Examiner	that initiated events resulting in death) Last	Due to (or as	a consequence of):						
. Box 68	The law requires that the death certifica the has been signed by the attending pt page 2 should be detached for use as it	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🕻 No	4☐Pregnant at	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у			ate of delive	ery Day Year
P.0	at the I by the	hys	9 Unknown	9□ Unknown							
Records, 1	w requires the been signed should be de		Part II. Other significant conditions	contributing to death b	ut not resulting in the u	inderlying cause giv	ven in Part I.	. IA	obacco use con Yes 2 No		he cause of death?
al Rec		Completed						24a. Was auto perfo 1 Yes		Were auto prior to co death? 1 Yes	psy findings available mpletion of cause of 2 No
Vital		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 📉 No	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpatie	ott		eath <i>(Check only c</i> Home 5 🔀 Resi	-,	40 11	
of		H- 1	27. Manner of Death	28a. Date of Inju (Month, Da			ry at		how injury occu		/)
ior	Attending F r death. actor: After by tha funer	atlo	1 Natural 5 Pending 2 Accident investigation	n	y Year) Injury		Yes 2 □ No				
Division	tal or Atto s after de al Diracto ad in by th	Certification:	3 Suicide 6 Could not be determined		ury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (City or To	Street and Num wn, State)	ber or Aura	al Route Number,
	To the Hospital or Attend within 24 hours after death To the Funaral Diractor: completely fillad in by tha	Medical	29a. Certifier (Check only one)	nysician: To the best miner: On the basis of and manner sta	of my knowledge, deat f examination and/or in ated.	h occurred at the til vestigation, in my o	me, date and plac opinion, death occ	e, and due to the surred at the time,	cause(s) and m date and place,	anner as s and due to	ated. the cause(s)
	Totl withi Totl comp	Σ	29b. Signature and title of certifier	7	/	29c. Licens		The state of the s	29d. Date signe		
			Hudfl		Nu		6473		Apri	1 12	, 2006
04.	H-L		30. Name and address of person who			•	00000+-	ALID MEL	0474	0	
2	Sta	ite	Hind Hamdan 31. Date filed (Month, Day, Year)	32 Registr	30 Opal C ar's Signature	ourt, H	agersto	wn, Md	. 21/4	Ų	
	Regist		APR 13	2006	w 1. 1.	carles					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 3,2006 10:31A M Grace Merriweather /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George Co. Doctors Community Hospital Lanham 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Nov. 22,1940 5. Social Security Number Birthplace (State or Foreign Country) Sex X⊓M 2□F **Funeral** North Carolina Director 577-56-5913 65 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, it a Modical Examinar must be multiled at 1 XYes 2 □ No Directo Maryland Prince George Lanham 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 6405 Brays Street 20706 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced and Mental Hygiene. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Licensed Practical Nurse Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Odessa Boykins Samuel Petty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Charlie Merriweather/ Spouse 6405 Brays Street Lanham, Maryland 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of important: If it any injury or o ō 1

Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Ft. Lincoln 4/10/2006 Brentwood, Md. 22. Name and Address of Facility Alexander S. Pope Funeral Homes, P.A 5538 Marlboro Pike Forestville, Md. 21. Signature of Funeral Service License P.A. 2<u>0747</u> HUR MOINTS 23a. Part 1. Erker the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Adult Respiratory
Due to (or as a consequence of): **Physician** Adult)istress /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last meumonre Due to (or as a consequence of): Examiner requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliven 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Wunknown Completed 24a. Was an autopsy performed 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? page 2 certificate has 2 No 1 Yes or Attending Physician: director 25. Was case relerred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1
Inpatient 2 □ ER/Outpatient 3 □ DOA 1 ☐ Yes 2 ☑ No Certification: To this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation after deat 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Thomicide 24 hours filled 29a. Certifie 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical npletely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 2 To the 29d. Date signed (Month, Day, Year) at title of certifier 29c. License number 29b. Signature D45660 fex W, M Bacie 30. Name Tress of person who completed cause of death (Item 23a) (Type, Print) 14300, GALLANT 31. Date filed (Month, Day, Year) APR 0 7 2006 32. Registrar's Si mature State Registrar

Suc Grace Merriweathe

			1 - For State Registrar	State of	Marylar				ealth a Death	and M	_	gien Reg. N	2006	129	58
	hysicia	544	1. Decedent's Name (First, Midd James M. Mall								2. Date of De Month	ath Da	ay Year	3. Time of 9:55	
	/Medic xamin		4a. Facility Name (If not institution Brooke Grove	on, give street and numb					Location of		April		c. County of Deat		
	neral ector		5. Social Security Number 579–16–7342			. last birthday) Yrs.		er 1 Year	pring If Under 2 Hours	24 Hrs. Min.	8. Date of Bird (Month, Da	th y, Year) Co	hplace (State or untry)	_
ryland	Ħ		Usual Residence of Decedent 10a. State 10b. County	,	10c. C	ity, Town or Lo	ocation				DEC. 3	1.2	ZU Wasi	ington,	
th the Ma	notified	Director	DC None	3	Was	hingto		p Code				10g. C	itizen of What Co	1 \ Yes untry?	2 No
Baltimore, Maryland 21215-0036 pemit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Dependentment of Health and Mental Hygiene.	diner must b	Completed by Funeral D	1707 Holly St 11. Marital Status 1 XNever Married 2 Mai	12. Was Deced Armed Force		42-	Was Deci		spanic Orig n, Mexican,	gin? (Spe , Puerto F	cify Yes or No Rican, etc.)		ted Stat 14. Race - Ame Black, White	ncan Indian,	
Baltimore, Maryland 21215-0036 Depenit. Peges 1 and 2 should be filed within 72 hours at Dependent of Health and Mental Hygiene.	dical Exac	eted by		If Yes, Give Year or Date ont's Education lest grade completed)	es: 19	16a. Dece	1 ☐ Yes dent's Usi	ual Occupa	Specify:	of working	20	16b. F	Specify: Wh:		
2121 led within lygiene.	Ta Me	Comple	Elementary/Secondary (0-12)	College (1-4	lor 5+)				luring most) racto:	r			Construc	tion	
Yland tould be fi	natic ever	To Be	17. Father's Name (First, Middle, Markos Mallus						Soph	ia Ma					
and 2 stream 27 length	her traun		19a. Informant's Name/Relation: Alexandra Mall			1707	Hol1	y St	. NW V	Wash:	ington	DC			
Feges 1	3		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		210	Place of Dispo cemetery, crei te of l	leave	n Cer	n. 2	Apri1 2006		Sil	ocation - City or ver Spri	ng, MD	
Ball permit Deper	any In		21. Signature of Funeral Service	una		5	130 W	lisco	nsin A	Ave.	eph Gaw NW Was	ler hin	's Sons gton, DO	Inc.	
Physi	ician dical		23a. Part1. Enter the disease, o shock, or heart fallure. Lis Immediate Cause (Final disease or condition resulting in death)		used the dea th line.	ith. Do not ent	er the mo	de of dying	, such as c	cardiac or	respiratory ar	rrest,		Approximate Interval Betw Onset and D	reen
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BOX 61 ath certific	deteched for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outco 1 □ Live birt 4 □ Pregnar 9 □ Unknow	h 2∏Feta ntattime of o	al death 3[Ectopic p Other (s	oregnancy pecify)					23d. Date of deli Month	_	ear ear
rds, F quires the	90	ρ	Part II. Other significant conditi	ons contributing to deal	th but not res	sulting in the u	nderlying	cause give	n in Part I.				use contribute to	the cause of de obably 4 [™] Our	
	page 2	Completed								_	24a. Was autop perfor 1 \(\text{Yes} \)		death?	copsy findings a completion of car	vailable use of
VITAL siclan: Th	director, p	o Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 No	Hospital:	-4:4 00	3.50.0		Othe	_		(Check only o				
VISION Of VITA Attending Physician: r death.	funeral	ıtlon: To	27. Manner of Death 1 Natural 5 ☐ Pendi	28a. Date of (Month, igation		28b. Time of Injury		28c. Injury Work	4 🗷 Nurs	21	e 5 ☐ Resid		6 ☐Other (Speciary occurred	ify)	
DIVISION all or Attended setter death	ed in by the	Certification:	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of	Injury - At h , etc. (Special	nome, farm, str	eet, factor				Bf. Location (S City or Tow	Street ai vn, State	nd Number or Ru e)	ral Route Numb	Θ <i>Γ</i> ,
DIN he Hospital or in 24 hours efte he Funeral Din	completely filled in by	edical	29a. Certifyir (Check only one)	ng Physician: To the be Examiner: On the bas and manne	is of examina	owledge, deatl ation and/or in	occurred vestigation	at the tim	e, date and inion, death	d place, ar h occurred	nd due to the o	cause(s date an	and manner as d place, and due	stated. to the cause(s)	
To the I	Eoo	Σ	29b. Signature and title of certific	5 0			29	c. License				29d. Da	ite signed (Month	Day, Year)	
B			P Clud	of Jagu	us			D39	793			Apr	il 7, 20	006	
			30. Name and address of person Christopher J.			m 23a) (Type, Prince		Lip D	r. 01	ney.	MD 208	332			
R	Sta egistra		31. Date filed (Month, Day, Year, APR 1 (istrar's Signa	atura 4	ede								

			State of Maryland / Departm 1 - State Registrar Certific	nent of Health and M cate of Death	lental Hygien	ZIIIIh	12959
	347		Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physicia	_	Frances Kiva Mager		April 5	, 2006 Year	12:05p M
).	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b.	City, Town, or Location of Death	4	c. County of Death	1
	LXUIIII	٠,	Holy Cross Hospital	Silver Spri	ng	Montg	omery
_	Funeral		o. coolar coolarly remode	Inder 1 Year If Under 24 Hrs. nths Days Hours Min.	8. Date of Birth (Month, Day, Yea		nplace (State or Foreign untry)
	Director		578-24-2150 1□M 2XF 80 Yrs. Mor	ntns Days Hours Min.	11/07/1		sh.,D.C.
	D		Usual Residence of Decedent				•
	uylar show		MD 10a. State 10b. County 10c. City, Town or Location Silver Sp				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	Sa-1	ct	nonegomery briver br				
	J within 72 hours after death with the Maryland plene. Than "natural; or items 23s or 28s-f show The Madical Examiner mail be incillised at	Director	10e. Street and Number 9101 Second Avenue	of. Zip Code 20910	10g. (Citizen of What Cou USA	untry?
	s 23c	Funerai		Decedent of Hispanic Origin? (Sp	activ Voc or No	14. Race - Amer	rican Indian
	item item	, E	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. If Yes.	, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	
3	i, or	by	If Yes, Give 1 ☐ Y 3 ☒ Widowed 4 ☐ Divorced Year or Dates:	es 2 No Specify:		Specify: W.	hite
21215-0036	tura stura		15 Decedent's Education 16a, Decedent's	Usual Occupation	16b.	Kind of Business/	ndustry
5	in 72	plet	(Specify only highest grade completed) [Give kind life. DO No. 10] [Elementary/Secondary (0-12) College (1-4or 5+)	of work done during most of work OT use retired)	ring		
בו בו	with piene r tha	Completed	Book	keeper	G	asoline	Stations
	景	4	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid		
Maryland	D D D D	To B	Edward DeBosky	Rosemo	nd Flora	bel Tra	chenberg
a	2 should and Men is marke aumatic			dress (Street and Number or Rui			
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic			6th Street S	ilver Sp	ring,Md	20910
Baltimore,	of He of Her		20a. Method of Disposition 20b. Place of Disposition cemetery, crematory	(Name of y or other place)	Date 20c.	Location - City or 1	Town, State
Ĕ	permit. Pages 1 Department of H Important: If ite any injury or ot		1 XBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) King Davi	d Mem.Pk 4/1	0/06 F	alls Ch	urch,Va.
a	partn ports v inju	0 3	21. Signatura Fundral Service Lightne 22. Name	TIP D. RINALDI	FUNERAL	SERVIC	E.P.A.
ñ	88 2 2 8		May Mustos 9241	Columbia Bl	vd.Silve	r Sprin	g,Md20910
			23a. Part1. Enter tile disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
	Physician	g 78	Immediate Cause (Final disease or condition Ventricular Fibr	rillation			Onset and Death
	/Medical	N	resulting in death) Due to (or as a consequence of):	TII CIOII			
п	Examiner		Sayuntially list conditions. b. End stage renal	disease			year
	D #	iner	if any, leading to immediate cause. Enter Underlying				
	ecute and -trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last c. Coronary artery Due to (or as a consequence of):	disease			
8760,	cate be executed physicien and s the burial-transit	E E	Due to (of as a consequence of).				
8/2	physi the l	dicai	d.				
×	the deeth certifi y the attending tched for use as	by Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deli	verv
BO	atten for u	ian	in the past 12 months?	pric pregnancy er (specify)		Month	Day Year
P.O. Box	t the de by the a tached t	ysic	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	Or (speedily)			
	res that t igned by be deta	F.	Part II. Other significant conditions contributing to death but not resulting in the underly	ying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
ds,	sign d be		Diabetes mellitus		1 ☐ Yes	2 ⊠ No 3 ☐ Pro	obably 4 Unknown
ö	w require been sig should t	ete	Hypercholesterolemia		24a. Was an	24h Were au	toney findings available
Division of Vital Records,	e la hes	Completed	<u> </u>		autopsy performed	prior to death?	topsy findings available completion of cause of
<u>_</u>	tician: The l certificate he rector, page		Atrial fibrillation		1 ☐ Yes 2 🛣	No 1 □ Yes	2 No
⋚	sicial certi recto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ EP/Outpatient 3	Othor	th (Check only one) ome 5 Residence	c Cotton (Con	.4.1
o	ding Physician: After this certific funeral director,	1-	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at Work?	28d. Describe how in		ally)
ou	ding F h. After funer	tion	1 ⊠Natural 5 □ Pending (Month, Ďaý Year) Injury 2 □ Accident investigation N				
ISI	or Attending Physician: after death. Director: After this certifica in by the funeral director.	fica	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, f	actory, office	28f. Location (Street		ıral Route Number,
á	a after i Dire	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, St	110)	
	Hospital 24 hours Funeral nely filled		29a. Certifier (Check only 2 ☐ Medical Exeminer: On the bast of my knowledge, death occ				
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	Medical	one) and manner stated.				
	To To Con	2	29b. Signature and title of certifier	29c. License number D0058965		Date signed (Mont) April 5	
,	Ì		round i sovida	50030303		*Pr T 7	, 2000
	,		30. Name and address of person who completed cause of death (Item 23a) (Type, Print		400 =		
				le Pike Suit	e 100 Roc	kville,	Md20852
	Sta Regist		31. Date filed (Month, Day, Year) APR 1 0 2006				

		1 - For State Registrar	State of	Marylan	-	artmen <i>rtificati</i>			and M	lental Hy	giene Reg. No.	006	2	960
Phys	ician	1. Decedent's Name (First, Middle, La: Benedict Joseph	*							2. Date of De. Month	Day			e of Death
/Me	dical	4a. Facility Name (If not institution, give		200)		4h Cihi	Tours of	Location o		April 7	· · ·	OO6 County of De	7:4	о рм
Exan	niner	Shady Grove Adve			1	,	kvil		n Death			ntgome		
- Funer	al	5. Social Security Number 6. S	ex 7	. Age (In yrs.			1 Year	If Under 2	24 Hrs. Min.	8. Date of Birt (Month, Da	th		Birthplace (Sta Country)	te or Foreign
Directo		5/9-38-1584	□ M 2 □ F	76	Yrs.	WOILIIS	Days	110013		Jan. 24			ennsyl	
and w		Usuaf Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Insid	City Limits
Many -1 • hc	ğ	Maryland Montgo	nery	S	ilver :	Sprin	g						1 🗆 1	′es 2.ΣXNo
death with the Maryland me 23a or 28e-f ehow Intel to notified at	il Director	10e. Street and Number 4215 Colie Drive)			10f. Zip 20	Code 906				10g. Citi	zen of What U	Country?	
<u>a</u> ₽ ₫	by Funeral	11. Marital Status 1 Never Married 2 A Married 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 Tes 2 If Yes, Give Year or Dat	es? [] No	1	Was Deced f Yes, spec	cify Cuba	spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)		14. Race - Ai Black, W Specify.Wh		Ι,
d 21215-0 filed within 72 ho Hygiene. other then "natur ent, tre Medical.	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	10.5.\	16a. Deced (Give life.	dent's Usua kind of wo DO NOT us	al Occupa rk done d se retired	ation during most ()	t of worki	ng	16b. Ki	nd of Busine	ss/Industry	
Z1Z	E	Elementary/Secondary (0-12)	College (1-4		L	ithog	raph	er			Gov	ernme:	nt	
Maryland 21215-0036 d 2 should be filed within 72 hours at th and Mental Hygiene. 27 is marked other then "natural", or treumatic event, the Madical Exern	To Be (17. Father's Name (First, Middle, Last, Vincent A. Manco					Val. Carried Co. St. Carried Co. Carried Co. St. Carried Co. St. Carried Co. St. Carried Co. St. Carried Co. St. Carried Co. St. Carried Co. St. Carried Co. St. Carried Co. St. Carried Co. St. Carried Co. St. Carried Co. St. Carried Co. St. Carried Co. St. Carried Co. St. Carried Co. St. Carried Co. Carried Co. Carried Co. Carried Co. Carried Co. C	18. Mothe		(First, Middle, y Franc				
Marylanc		19a. Informant's Name/Relationship (Marcia Ann Manco								er Spri				
Fages 1 and nent of Health int: If item 27 ury other to		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐		ate	allace of Dispo emetery, crer	natory or o	ther plac	· A	pril 200	Oate 9,			or Town, State	
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 1e marked englishing up other treumetice.	X)	4 Donation 5 Other (Specif		1	-					Funeral			a, Viro	
		23a. Part Lenter the disease, or com shock, or heart failure. List only	pfications that cal	hed the deat ch line.								1.	Approxi	
Physicia /Medic Examine	al	Immediate Cause (Final disease or condition resulting in death)	aDue to (o	r as a conseq						TIS		<u> </u>		
	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c	r as a conseq		44)10	<i>1</i> 70	VI	10E0	MONI	2			
18760, cate be executed physicien and the burial-transit	Ical		d											
I Records, P.O. Box 68760, The law requires that the death certificate be executed atte has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 ☐ Feta nt at time of d	Ideath 3□	Ectopic pr Other (sp					2	23d. Date of o	delivery Day	Year
ds, P. uires that signed b	d by Pt	Part II. Other significant conditions of		th but not res	_	nderlying c		_		23e. Did t	1	/	to the cause Probably 4	
Vital Records, sician: The law requires to certificate has been signe rector, page 2 should be a	Ω									24a. Was autop		24b. Were prior t	autopsy findir o completion	gs available of cause of
Vital F lician: Th certificate rector, pag	ပိ	25. Was case referred to medical			- · · · · · · · · · · · · · · · · · · ·			00 Pl	-4 Da -4h	1 Yes	2 No	1 🗆 Y	es 2□No	
f Vital Roysician: The is certificate hadirector, page	To Be	examiner?	Hospital:	patient 2 🗆	ER/Outpatier	t 3 □ DC	Othe	or		n <i>(Check</i> on <i>ly c</i> me 5 ☐ Resid		Other (S	pecify)	
on of ding Phy h. After thi funeral of	tlon: T	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of (Month)		28b. Time of Injury		8c. Injury Work		1	28d. Describe I			,,	
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not b	28e. Place o	of fnjury - At ho g, etc. <i>(Specif</i>	ome, farm, str	eet, factory	y, office			28f. Location (S City or Tox			Rural Route N	/um <i>b</i> er,
Hospit 24 hour Funere letely fills	Medical	29a. Certifier Check only one) Certifying Pt 2 Medical Exam	ysician: To the bas niner: On the bas and manne	is of examina	wledge, death	n occurred vestigation	at the tim , in my op	ne, date and pinion, deat	d place, a	and due to the ed at the time,	cause(s) date and	and manner place, and o	as stated. ue to the caus	se(s)
To th Within To th compl	Me	29b. Signature and title of certifier	٨					e number				T	onth, Day, Yea	r)
10) Osat	M			1	Do	056	34	5	04	109	106	
		30. Name and address of person who	completed cause	of death (Item	n 23a) (Type,	Print)	174	5 E	KE	5 CUTIV	RM	ARK	CIRC	MD
	State istrar	31. Date fifed (Month, Day, Year) APR 10	2006 32. 76	gistrar's Signa	ture A	ade	7							

			For Stata Registrar	State of	Maryland		artment rtificate					Reg. No.	006		129	61
	Physici	an	1. Decedent's Name (First, Mide							1	2. Date of De. Month	Day		ar	3. Time o	
	/Medic	0.00	Fairy	McCray			45 Ch. To	041	Looption	f Dooth	April		2006 County of D	- Dooth	7:25	рм
	Examin	er	4a. Facility Name (If not instituti 14333 Georgia				4b. City, To		Spri:			46.			mery	
			5. Social Security Number		7. Age (In yrs. las	st birthday)	If Under 1	Year	If Under 2	24 Hrs. 8	B. Date of Birt	th		Birthp	ace (State	or Foreign
	Funeral Director		287-12-3080	1 M 2 F	92	Yrs.	Months I	Days	Hours	Min.	'eb. 18	3, 19	14 7	Coun Arka	nsas	
	Pi _		Usual Residence of Decedent		40- 67-	*									0d. Inside (City Limite
	anylar ehow	<u>_</u>	10a. State 10b. Coun	ry	Toc. City,	Town or Lo	cation							'		2% No
	Ne M.	Directo	Maryland Mont	gomery	Si	ilver	Sprine					10a Citi:	zen of Wha	t Coun	try?	
	a or	ā	14333 Georgia	Avenue #2	04			0906	5			. 09. 01	USA		,	
	ne 23	Funeral	11. Marital Status		dent Ever in U.S.	. 13.	Was Deceder	nt of His	panic Orio	gin? (Spec	ify Yes or No)-	14. Race - /			
36	72 hours atter death with the Maryland netural', or Iteme 23a or 28e-f ehow dical Exemirer must be mullised at	by Fun	1 Never Married 2 Ma	rried 1 ☐ Yes	² xNo		If Yes, specify 1 ☐ Yes 2<			i, Puerto R	ican, etc.)	h 400	Black, V Specify:	White,	etc. :k	
21215-0036	72 hours "netural",		15. Decede	ent's Education		16a. Dece	dent's Usual kind of work	Occupat	tion	t of working	7	16b. Kir	nd of Busin	ess/Ind	dustry	
215	within 7 ene. than "n	Completed	Elementary/Secondary (0-12)	completed) College (1	-4or 5+)	life.	DO NOT use	retired)	aring most	OF WORKING	,					
	be filed within 72 ho ital Hygiene. id other than "netur event, ire Medical	Co	12	(-1)		Hor	nemake:		10 Motho	r's Nama	First, Middle,		own Ho	ome		
and	be fill H d oth	Be	17. Father's Name (First, Middle Shedrick Jone								lorganf					
Maryland	s 1 and 2 should be if Health and Mental I Item 27 is marked of other treumatic eve	은	19a. Informant's Name/Relation			19b Maili	na Address (Street au			Route Numb			ite, Zip	Code)	
Ma	nd 2 salth an 27 le r		Cassandra McCı		er		_				204, 5					20906
ē,	t Heal them 2		20a. Method of Disposition		20b. Pla	ce of Dispo	sition (Name	of		April			cation - Cit			
Ę	Page nt: #		1 → Surial 2 Cremation 4 Donation 5 Other		State		Cemet			2006		Tole	do, C	hic)	
Baltimore,	permit. Pages 1 Department of H Important: If Ite any injury or of		21. Signature of Funeral Service	e Licensale		F 50	Name and rancis 00 Uni	Address vers	coll coll sity	ins F Blvd,	uneral W, Si	Hom Llver	e Inc	ng,	MD 2	20901
			23a. Part1. Enter the disease, shock, or heart faillure. Li	or complications that cost only one cause on a	aused the death.	Do not en	ter the mode	of dying	, such as	cardiac or	respiratory a	rrest,			Approxima Interval Be	tween
H	Physician		Immediate Cause (Final disease or condition		olemic S	Shock								4	Onset and	Death 4/6
	/Medical		resulting in death)		or as a conseque										, =	1, 0
	Examiner	_	Sequentially list conditions.	D	peritone		ematoma	a						4	./2 &	4/6
	ed self	line	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	2	red Abdo		l Aort	i	\nour	TTC M					/2 &	4/6
	xecut and al-trar	Examiner	that initiated events resulting in death) Last		or as a conseque		L AULC.	IC P	mear	уын					. / <u>L</u>	1/0
8760,	icate be executed physicien and the burial-transit			Ather	osclerot	cic Ca	ardiov	ascu	ılar	Disea	ıse					
9	g phy as the	edic														
O. Box	The law requires thet the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live b	come of pregnand irth 2 Fetal of ant at time of dea own	leath 3[⊒Ectopic prec ☑ Other (spec					2	23d. Date o Month		ny Day	Year
P.O.	res thet the igned by be detact	/ Ph	Part II. Other significant cond				inderlying cau	ise give	n in Part I.		23e. Did t	obacco u	se contribu	ite to th	ne cause of	death?
ds	uires r sign td be	d by	Hypertension,	Acute Rena	l Failur	ce					1 🗆	Yes 2	□No 3[Prob	ably 4 🛚	Unknown
Records,	ne law require s has been si ge 2 should t	Completed										psy ormed?	prio dea	r to cou	psy findings	s available cause of
Vital	in: Ti ificate or, pa	e Cc	25. Was case referred to medi	cal					26. Place	of Death	1 Yes		1	105	2□No	
>	Physician: r this certifica ral director, I	To B	examiner? 1 ☐ Yes 2 ☑ No	Hespital	npatient 2 E	R/Outpatie	nt 3 DOA	Othe	ır: 4 □ Nu	rsing Hom	e 5X Resi	idence (6 Other (Specif	v)	
J of	nding Physician: The la th. : After this certificate has e funeral director, page 2		27. Manner of Death 1 ☑ Natural 5 ☐ Pen	28a. Date (Mont	of Injury h, Day Year)	28b. Time o	of 28	c. Injury Work	at ?	2	8d. Describe	how injur	y occurred			
<u>ö</u>	Attending r death. ector: After you the fune	atic	2 Accident inve	stigation			М		es 2 🗆							
Division	or Attencester death	Certification:		rmined 288. Place	of Injury - At honing, etc. (Specify)		reet, factory,	office		2	8f. Location (City or To			or Rura	il Route Nu	mber,
_	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Co	29a. Certifier 11 Certific (Check only 2 Madic	ying Physician: To the al Examiner: On the ba	best of my know asis of examinationer stated.	ledge, deat on and/or in	th occurred at	the tim	e, date an einion, dea	nd place, a oth occurre	nd due to the d at the time,	cause(s) date and	and manne place, and	er as s	tated. the cause	(s)
	Vithin Fo the Somple	Me	29b. Signature and title of certi	tler)					number				e signed (#			
	4)	1				D478	367		P	April	7, 2	2006)	
	1		30. Name and address of person	on who completed caus M.D 4701 R				, Ro	ckvi	lle,	MD 208	352				
A STATE OF THE PARTY OF THE PAR	Sta Regist		31. Date filed (Month, Day, Ye.	0 2006 33 R	egistrar's Signatu	Jre So	who									

5-02281 urphy, John	1- For State Registrar	State of Maryla	ind / Departn	rint in Black ment of Healt cate of Death	h and		, ,	Reg. No.	06 1296
Physiciaı ledical Examin							2. Date of De Month		3. Time of Death
La LXAIIIII	JOHN WEDS	STER MURPHY		г _			April 2, 2		6:53PW
	3892 Laurel G	ot institution, give street and nu irove Rd.	mber)			MD 21632		4c. County of Caroline	
Funeral Director	5. Social Security Num 215-38-178	35 1XM 2 F	7. Age (In yrs. last b	irthday) If Unde Months Yrs.		If Under 24Hrs. Hours Min.	8 Date of E		 9. Birthplace (State or Fore Country) MARYLAND
>	Usual Residence of De		104						
w any	10a. State 10b	o. County	10c. City, Tow	n or Location					10d Inside City Lim
and sho	MARYLAND (CAROLINE	FEDERA	ALSBURG					1 Yes 2X
Aaryland 28a-f show 1 at once.	10e. Street and Numbe	er		10f. Zip	Code			10g. Citizen of Wh	nat Country?
3a or		EL GROVE ROAD			2163	2		US	SA
72 CL 52 hours after death with the Maryland n"matural", or items 23a or 28a-f she al Examiner must be notified at once	11. Marital Status 1 X Never Married		edent Ever in U.S. rces? 2 X No	13. Was Deceder If Yes, specify	t of Hispa Cuban, M	nic Origin? (Sp lexican, Puerto	ecify Yes or N Rican, etc.)	lo- 14. Race White	- American Indian, Black, e, etc.
after al", o	3 Widowed	4 Divorced If Yes, Give Year or Dates:		1 Yes 2	X No s	specify:		Specify:	WHITE
ours:		ation (Specify only highest grad		. Decedent's Usual C	ccupation	(Give kind of w	ork done	16b. Kind of Bu	
72 h	15. Decedent's Educa Elementary/Seconda 17. Father's Name (Firs	ary (0-12) College (1	-4 or 5+)	ng most of working life	DO NOT	use retired)			
03(<u>-</u>	4	TF	RUCK DRIVE	R	,		TRANSPO	ORTATION
5-0 ed w fygic othe lihe N	3 17. Father's Name (Firs	st, Middle, Last)			18.	Mother's Name	(First, Middle,	Maiden Surname)	
21215-0036 ould be filed within 7 Mental Hygiene. marked other than e event, the Medica	JOHN WEBST	TER MURPHY			В	ONNIE M	ERCEDES	S PRINCE	
ould days	2 19a. Informant's Name/	/Relationship (Type, Print)	19	9b. Mailing Address	(Street a	nd Number or R	tural Route Nu	ımber, City or Towi	n, State, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after de Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or injury or other traumatic event, the Medical Examiner on	LUCILLE CO 20a. Method of Disposi 1 Burial 2 X	Cremation 3 Removal fro	20b. Place om State crema	112 JONES of Disposition (Name atory or other place)	e of cemet	ery,	Date	20c. Location -	City or Town, State
ting t. Pa tmer tmer rtam	4 Donation 5		CREMATO	ORY OF DELM			2006		, DELAWARE
Bal permi Depar Impo injur	21. Signature of Funera	el de sele	lu	106 MAI	N STE	REET, EA	AST NEW	. BOX 20 MARKET	MD 21631
Physician // /Medical	failure. List only o	isease, or complications that ca one cause on each line.	used the death. Do r	not enter the mode of	dying, suc	ch as cardiac or	respiratory ar	rest, shock, or hea	Approximate Interv Between Onset ar Death
Examiner	Immediate Cause (Fina or condition resulting in	n death) Due to (or as a	consequence of):	rieau					Deali
	Sequentially list condition if any, leading to immediate cause. Enter Underlying	diate Due to (or as a ng Cause	consequence of):						
ted d insit		initiated	consequence of):						
ertificate be executed ding physician and e as the burial - transit	UNPENDED IF FEMALE: 23b. Was decedent pregpast 12 months?	a. AMENDED							
68760, sertificate be riding physicise as the buri	IF FEMALE: 23b. Was decedent preg past 12 months?	gnant in the 23c. If yes, o	utcome of pregnancy	2 Fetal death	3	Ectopic pregnar	псу	23d. Date of o	delivery Day Year

Division of Vital Records, P.O. Box (
To the Hospital or Attending Physician: The law requires that the death or within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attent completely filled in by the funeral director, page 2 should be detached for use

Burial Z A Cremation	3 Removal from State	crematory or other place)				
4 Donation 5 Other Spec	7	CREMATORY OF DELL		5/2006	DELMAR, DEL	AWARE
21. Signature of Funeral Service Lic	Feller	106 MAI	Address of Facility FUNERAL HO N STREET,	EAST NEW	MARKET MD 21	631
23a Part I. Enter the disease, or con failure. List only one cause on	mplications that caused the each line.	death. Do not enter the mode of	f dying, such as cardia	c or respiratory arres		Approximate Interv Between Onset an
Immediate Cause (Final disease or condition resulting in death)	a. Contact Gunshot V Due to (or as a conseque					Death
Sequentially list conditions,	b.					
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a conseque c.	ence of):				
events resulting in death) Last	Due to (or as a conseque d.	ence of):				
UNPENDED	AMENDED					
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkno Part II. Other significant condition	23c. If yes, outcome of	2 Fetal death	3 Ectopic pres	gnancy	23d. Date of delivery Month Day	Year
1 Yes 2 No 9 Unkno	wn 9 Unknown	of death 5 Other (Spec	ify)			
Part II. Other significant condition	s contributing to death bu	not resulting in the underlying	cause given in Part I.	23e. Did tob	acco use contribute to the	cause of death?
5 5				1 Yes	2 No 3 Probably	y 4 Unknown
				24a. Was ar autops		y findings available
				perform 1 Yes 2		2 No
25. Was case referred to medical		2	6.Place of Death (Che	ck only one)		
	Hospital: 1 Inpatient	2 ER/Outpatient 3 D	DA Other Nur	sing Home 5 R	esidence 6 🗸 Other: Sc	ene
1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investig 3 Suicide 6 Could n 4 Homicide 29a Certifier 1 Certifying Phys one) 2 Medical Examir 29b. Signature and title of certifier	A m = 2 2000	28b. Time of Injury 2 FOUND: 4:00:00 PM	8c. Injury at Work? 1 Yes 2 ✓ No	28d. Describe ho Subject shot	w injury occurred self	
3 V Suicide 6 Could n 4 Homicide	ot be 28e. Place of Injury	- At home, farm, street, factory,	office building, etc.	or Town, Sta	reet and Number or Rural R ate) Grove Rd., Caroline,	
29a. Certifier 1 Certifying Physone) 2 Medical Examir	ician: To the best of my kn	owledge, death occurred at the	time, date and place, a	ind due to the cause	(s) and manner as started.	
Z W MOUNTED EXCHANGE	ner: On the basis of examina and manner stated.	tion and/or investigation, in my	opinion, death occurre	d at the time, date ar	nd place, and due to the car	use(s)

O.C.M.E.

April 3, 2006

Registrar

State 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of beath (Item 23a)

Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 ORIGINAL

Type or Print in Black Indelible Ink. Ensure	e All Copies Are Legible.	
State of Maryland / Department of Health an	nd Mental Hygiene	1 (1)
State of Maryland / Department of Health an Certificate of Death	Reg. No. U U b	Tane
ast)	2. Date of Death	3. Tir

		For	State		aryland /	Depa	artmen	t of H	lealth a	and M			_	12963	
		1 - State Registrar 1. Decedent's Name (First, Middle	- Look			Cei	uncat	e or i	Death		2. Date of D	Reg. No.	000	1 (700	
Physicia	ın										Month	Day		3. Time of Death	
/Medic		Robert L 4a. Facility Name (If not institution			ux		Al- City	Tour	r Location of	of Death	April		2006 County of Deat	1:20 P M	
Examine	er	Lorien Health								or Death			•	.n	
Formanal		5. Social Security Number	6. Sex	_	e (In yrs. last b	irthday)	If Under		Airy If Under	24 Hrs.	8. Date of B		Carroll	holace (State or Foreign	
Funeral Director		218-32-2000	1 XM 2□ F		87	Yrs.	Months	Days	Hours	Min.	8. Date of B	ay, Year	919 Ma	hplace (State or Foreign buntry) Tyland	
סי		Usual Residence of Decedent													
rylan		10a. State 10b. County	* *		10c. City, Tov									10d. Inside City Limits	
e Ma	cto	Maryland Car	roll		Mou	int A	Airy							1 XYes 2 No	
or 28	Funeral Director	10e. Street and Number					10f. Zip	Code	01.00			10g. Citi	zen of What Co	•	
ath w	ra l	713 Midway Av							2177				U.S.		
er de	nne	11. Marital Status	Armed I	Forces?	Ever in U.S.	13. \	Nas Deced f Yes, spec	lent of H of Cuba	ispanic Ori ın, Mexicar	gin? (Sp 1, Puerto	ecify Yes or N Rican, etc.)	0-	 Race - Ame Black, Whit 		
s afte	by F	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	If Yes, Give			1 ☐ Yes 2 🛣 No Specify:							Specify: Wh:	ite	
hour turel	edr		t's Education	Dales.	16:	Pecec	lent's Usua	d Occur	ation			16h Kii	nd of Business/	Industry	
in 72 n "na	Completed	(Specify only highest grade completed)				(Give life. L	kind of wo	rk done o	during mos f)	t of work	ing	100.10	o. Kind of Submodumingstry		
iene r tha	Eo	Elementary/Secondary (0-12) College (1-4or 5+)				Far	mer					Fa	rming		
be filed within 72 hours after death with the Maryland tal Hygiene. d other than "naturel", or items 23a or 28e-f show event, the Madical Examinar must be muffiled at	Bec	17. Father's Name (First, Middle,					18. Mothe	r's Nam	e (First, Middle	, Maiden	Sumame)				
Ald be Alenta rked tlc ev	일	Hobart M. M	ıllineaux					j		Ne	11ie	M. W	latkins		
2 should and Men Is marke sumatic		19a. Informant's Name/Relations	hip (Type, Print)		19	b. Mailin	g Address	(Street	and Numbe	er or Rur	al Route Numb	per, City or	r Town, State, 2	Zip Code)	
end 2 Balth a n 27 li		Allen R. Herndo	n - Neph	ew		1203	0 Loc	kin	gbill	Roa	d, Ke	ymar,	Maryla	and 21757	
of He of He item		20a. Method of Disposition	0. 🗆 🗅 🗅	- 01-1-	20b. Place cemet	of Dispo	sition (Nar	ne of ther plac	(e)	(Date	20c. Lo	cation - City or	Town, State	
Pages nent of ant: If it any or o		1 Daurial 2 □ Cremation 1 □ Datation 5 □ Other (S		n State	Montg					4/12	/06	Dama	scus, M	laryland	
permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28e-f show any injury or other traumatic event, the Modical Examiner must be multiled at once.	Ì	21. Signature of Funeral Service	Licensee /	•	,	22 Mo	Name an	d Addres	ss of Facilit	y ame	DΛ	Funa	ral Hom	10	
89 = 9		Tovert L.	Will	u	m	126	401 1	Ride	e Roa	d.	Damasci	15. M	aryland		
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused each lin	the death. Do	not ent	er the mod	e of dyin	g, such as	cardiac	or respiratory	arrest,	•	Approximate Interval Between	
Physician		Immediate Cause (Final disease or condition			is with									Onset and Death 1 wk.	
/Medical		resulting in death)	Due to	o (or as	a consequence	of):									
Examiner		Sequentially list conditions.	b		d demen		with	psy	chosi	S				yrs.	
sit s	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a consequence												
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	/Me	IF FEMALE:	23c. If yes, o	utcome	of pregnancy		-			-			12d Data of dal		
atten for u	Physician/M	23b. Was decedent pregnant in the past 12 months?	2 Fetal deat	etal death 3 Ectopic pregnancy						4	3d. Date of del Month	Day Year			
at the de by the a tached i	ysi	1 □ Yes 2 □ No 9 □ Unknown	9□ Unk				, (-)								
that ned b	y P	Part II. Other significant condition	ons contributing to	death b	ut not resulting	in the ur	ndertying c	ause giv	en in Part I.		23e. Did	tobacco u	se contribute to	the cause of death?	
uires n sign	d by	Atrial fibrill	ation, Re	na⊥	insuff	1016	ency,	Dys	pnagi	.a ,	10	Yes 2	No 3∏Pr	obably 4 Unknown	
w require been sign should b	Completed	Gastroesophage	al Reflux	Di	sease						24a. Was	s an	24b. Were au	topsy findings available	
sician: The lav certificate has irector, page 2	E C											ormed?	prior to death?	completion of cause of	
		Benign Prostat 25. Was case referred to medica		tro	phy, Hy	poa.	Lbum1	n	26 Place	of Deat	1 Yes		1 Ll Yes	2X No	
	To Be	examiner? 1 ☐ Yes 2 🛣 No	Hospital:	Inpatie	nt 2 ER/O	utpatien	1 3 DC	A Oth	ar		-		Other (Spec	cify)	
g Phy er this veral c	<u>.</u>	27. Manner of Death	28a. Date		ry 28b.	Time of Injury		8c. Injun	at at		28d. Describe			,,	
ath. rr: After	atlo	1 Natural 5 Pendir 2 Accident investi	gation	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	7 (04.7)	mary	М		Yes 2 🗆	No					
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telon rs aft al Di	Certification;	building, etc. (Specify) City or Town, State)													
	edical	Check only 2 Medical	g Physician: To the Examiner: On the	ne best	of my knowledg	je, death	occurred	at the tim	ne, date an	d place,	and due to the	cause(s)	and manner as	stated.	
the F in 24 the F the F	ledi	one)	and ma	nner sta	ited.						us uno (IIIIO)				
To To con	Σ	29b. Signature and title of certifie	v Re	: 1	11.	14	(A) 290		number				signed (Monti		
		Puller	v re	L	LU	11/1		D547	49			A	pril 10	, 2006	

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

April 10, 2006

1 Toll House Avenue, Frederick, Maryland 21701

State

Allen Reilly M.D.

31. Date filed (Month, Pax, Year) 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene [] [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** THOMAS JUNIOR MARSHALL 2006 April 7, 9:34 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 16). 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ★ M 2 F 219-20-3584 78 Director 1927 Maryland Usual Residence of Decedent with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits ir than "naturel", or iteme 23a or 28e-f ehow Tre Medical Examiner must be notified at 1∏Yes 2∏No Directo Maryland Frederick Woodsboro 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5 South 3rd Street 21798 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Amed Forces? 1 Payes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: WWII 1 ☐ Yes 2 No Specify: þ Specify 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Depertment of Health and Mental Hygient Important: If item 27 le marked other than eny injury or other traumatic event, Italy once. Cabinet Maker Lin-Mar Plastics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas Marshall Rosalia Kreitz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah V. Marshall / Wife 5 South 3rd Street, Woodsboro, MD 21798 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State □ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Church of Brethren Cem. 4/11/06 | Rocky Ridge, Maryland 21. Signature of Faneral Service Licen ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 FAST MAIN STREET, THURMONT, MD 21788 23a. Part1. Exter the disease, or complication that can shock, or hear failure. List only one cause on each Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac of Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed ettending physicien and I for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No the 9 Unknown 9 Unknown page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Demetica 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy certificate 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: ဥ 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Funeral Diractor: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred Injury 1 ANatural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a To the Funeral E 1 Certifying Physician: To the hest of my knowledge, death occurred at the time date and place and due to the daweste) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 52119 lot WA 30. Name and to completed cause of death (Item 23a) (Type, Print) 8100 Goodbuck Rd; 32. Registrar's Signature 1 2006 Registrar

		•	For State Registrar		Marylan	d / Depa		t of H	ealth a		ental Hy		0 6	129	65
			1. Decedent's Name (First, Middle, La	ist)							2. Date of De Month	ath Day	Year	3. Time of	Death
	iysicia Medic		Lulu Elizabeth	Miller							April	5	2006		\mathbf{P}^{M}
	camin	-	4a. Facility Name (If not institution, gi	ve street and num	ber)		4b. City,	Town, or	Location o	f Death		4c. C	ounty of Dea	ıth	
			Glade Valley Nur	sing Hom	1e		W	a1ke	rsvil	1e		Fr	ederic	k	
Fun	neral				. Age (In yrs.		If Under Months	1 Year_ Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da	v. Year)	9. Bir	thplace (State o	r Foreign
Dire	ctor		214-03-5693	1 □ M 2 🙀 F	94	Yrs.					August	21,1	911 Ma	ryĺand	
pu *	200	-	Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation							10d. Inside Cit	its Limite
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er de	1	ă l	11. Marital Status 1X Never Married 2 ☐ Married	12. Was Deced Armed Ford 1 □ Yes	ces?	.5.	If Yes, spec	ify Cuba	n, Mexican	Puerto F	cify Yes or No Rican, etc.))-	Black, Whi	erican fndian, te, etc.	
rs aft	B	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give			1 □ Yes 2	2 I¥No	Specify:			5	specify: Wh	ite	
Maryland 21213-UU35 Id 2 should be filed within 72 hours after deeth with the Maryland th and Mental Hygiene. 27 is marked other then "natural", or items 23s or 28s-f show	4	ed	15. Decedent's B			16a. Dece	dent's Usua	l Occupa	ation.			16h Kind	of Business	/Industry	
57 ni	3	Completed	(Specify only highest gi	ade completed)		(Give	kind of wor DO NOT us	k done d	luring most	of working	ng	TOD. INIT	201 003111033	e in dustry	
A History	Ne.	E	Elementary/Secondary (0-12)	College (1-	4or 5+)		f Rea					Bus	iness	Forms	
filed Hygin	nt,	Ö	17. Father's Name (First, Middle, Las	t)					18. Mothe	r's Name	(First, Middle				
d be solution) 0	To Be	Charles Richard N	filler					Anna	be1	Robins	son			
Though M	mati	ř	19a, Informant's Name/Relationship			19b. Mailir	na Address	(Street a			i Route Numb		Town, State.	Zip Code)	
Mar ith ar 27 to	ir D	1	Annabel Ruppert/			1	ñ.,				.4, Th	•		111	
e ± ± €	ŧ,	- 1	20a. Method of Disposition	MICCC	20b. P	lace of Dispo	sition (Nam	ne of			ate			Town, State	
Peges nent of i	5		1 Burial 2 Cremation 3		tate	emetery, cier aceham	-			/9/2	006				
Baltimore, Demit. Peges 1 at Department of Hea Important: if Item	nje.	1	4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service, Lice		GI.				1		ffer F			Marylan	ш
ESITIMORE, MARYIANG 21215-UU36 permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or iteme 23a or 28a-1 show	once	2	Bully I do	1		1	621 0	poss	untow	n Pi	ke, Fr	ederi			
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8 / 50, at the be executed the	1.	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	r as a consequence of as a consequence		Acy		so					ylo	us.
UIVISION OT VITAL RECORDS, P.O. BOX DE TO the Hospitel or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funerel Director; After this certificate has been signed by the attending ph	completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		th 2 ☐ Feta nt at time of d	fdeath 3	Ectopic pro					23	d. Date of de Month		/ear
quires tha	ed blu	ρ	Al : 1 Al The Manager of the Manager								3e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown				
DIVISION OT VITAI HECONGS, to Attending Physician: The law requires tarter death. Director; After this certificate has been signe	age 2 sho	Completed	24a. We aul payl								24a. Was autor perfo	opsy prior to completion of cause of formed?			
tifice	tor, I	0	25. Was case referred to medical						26. Place	of Death	Check only				
ysici	direc	ToB	examiner? 1 ☐ Yes 2 ☐ No	Hospitaf: 1 ☐ In	patient 2	ER/Outpatier	it 3□ DO	A Othe	-		ne 5□Resi		□Other (Spe	ecify)	
JON O	funeral	tlon:	27. Manner of Death 1		Injury , Day Year)	28b. Time of Injury	M 2	8c. Injury Work	at ·	2	8d. Describe				
DIVIS of or Atte after dea	d in by th	Certification:	3 Suicide 6 Could not 4 Homicide determined	reet, factory, office 28f. Location (Street and Number or Rural R City or Town, State)					ural Route Numi	ber,					
Hospite 24 hours Funerel	etely fille	edical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysicien: To the t miner: On the bas and manne	sis of examina	wledge, death tion and/or in	occurred a vestigation,	at the tim in my op	e, date and pinion, deat	d place, a h occurre	and due to the	cause(s) a date and p	nd manner as	s stated. e to the cause(s))
To the To the	ldwo	Me	29b. Signature and title of certifier				29c	License	number			29d. Date	signed (Mont	th, Day, Year)	
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11			10. Nam, and address of person who	Cu hoc	147	5 TA	Print) NEY	M	٤ (Fres) м	D	2170	2	
Re	Star egistra		31. Date filed (Month, Bay, Year)	2006	gistrar's Signa	eruti	book	,							

		•	For State Registrar	State of M	larylan	•	irtment of F tificate of		d Mental	Hygier	2000	12966		
Н	Physicia	an	1. Decedent's Name (First, Middle, Last Leon Miller)					2. Date Monti Marc	1 [Day 2006	3. Time of Death 2:00 P M		
,	/Medio Examin		4a. Facility Name (If not institution, give		.)		4b. City, Town, o				4c. County of Deat			
			1438 FaNNIE Dorse 5. Social Security Number 6. Se		ne /ln ure	last birthday)	Sykesvi	11e	Hrs. 8. Date	of Birth	Carroll	hplace (State or Foreign		
	Funeral Director		078-28-0393	ŜM 2□F	77	Yrs.	Months Days		Min. (Mont	h. Dav. Ye:	ar) Co	garia		
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits		
	Maryla faho	ţō	MD Carroll			kesvil						1 ☐ Yes 2 No		
	th the	Director	10e. Street and Number		J	RCOVII	10f. Zip Code			10g.	Citizen of What Co	untry?		
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36	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. and Mental Hygiene. is marked other than "natural", or thams 23s or 28s-f show aumstic event, the Madical Examinar must be notified at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 ▼ Yes 2 □ If Yes, Give Year or Dates	? No 19	וו	Yes, specify Cub	Specify:	Puerto Rican, et	;.)	Black, White			
2	72 hou		15. Decedent's Ed (Specify only highest grad	ication le completed)	19	16a. Deced	lent's Usual Occup	during most of	f working	16b. Kind of Business/Industry				
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ylar	should be filed vind Mental Hygie marked other t	To B	Oshin Merametdjian Alice Babikian											
_	コムトサ		19a. Informant's Name/Relationship (7 Sylvie Merian	_{уре, Print)} Neice			g Address <i>(Street</i> ast 38th				ty or Town, State, 2	7ip Code) 10 1 6		
ē,	of Health		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of	1	Date	-	. Location - City or	Town, State		
altimore,	Page ment c ent: if		1	•	° √Gan Vet	rrison erans	Forest Cemetery	Apı	ril 11,	2006	Owings	Mills, MD		
Ball	permit. Pages 1 and Depertment of Healt importent: if itam 2 any injury or other once.		21. Signature Li Fineral Service Licen	Colo	aj						% Cremato infield,	řy, Piá. MD, 21784		
		1	23a. Part . Enter the disease, or composh ock, or heart failure. List only of	lications that cause ne cause on each	ed the death line.		_			ory arrest,		Approximate Interval Between Onset and Death		
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	pe jis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequ	uence of):								
ń	cate be executed physicien and the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or a	s a consequ	uence of):								
8760	ate be hysicie the bur	dical	(d										
9	leath certific attending p		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom							23d. Date of del	ivery		
.О. Вох	The law requires that the death certificate be executed sie has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	by Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown	10-	_	Month	Day Year							
rds, P	w requires that been signed b should be deta	d by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute 1 Yes 2 No 3									the cause of death?		
Records,	The law re- le has bee age 2 sho	Completed	Chunic Obstructive pulmonary Dispose 24								Was an autopsy findings available prior to completion of cause of death?			
Vital	ilcian: Th certificete rector. pag	BeC	25. Was case referred to medical examiner?						1 Death (Check		No 1 ☐ Yes	21) No		
ot O	Physic this corral dire	္	1 Yes 2 No 27. Magner of Death	Hospital: 1 ☐ Inpat		ER/Outpatien	1 3LI DOA		ng Home 5		6 ☐Other (Specially occurred	cify)		
0	th: After: After	ation	1 Natural 5 Pending 2 Accident investigation	(Month, D	ay Year)	Injury	28c. Inju Wo M 1	rk? Yes 2∐No		ALDO HOW II	njury occurred			
Division of	al or Atter s after dea if Director ed in by the	Certification;	3 Suicide 6 Could not be determined		njury - At ho		eet, factory, office		ocation (Street and Number or Rural Route Number, city or Town, State)					
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medicai (29a. Certifying Phy (Check only one) 1 Certifying Phy 2 Medical Exam	rsician: To the besiner: On the basis and manner s	of examina	wledge, death tion and/or in	occurred at the ti	me, date and popinion, death	place, and due to occurred at the	time, date	e(s) and manner as and place, and due	stated. to the cause(s)		
	To the withing To the complex	Σ	29b. Signature and title of certifier	1/10	~		29c. Licen		777)		Date signed (Mont	h, Day, Year)		
•	WILA		30. Name and address of person who	ompleted cause =	And Item	23a) /Tuna	Print)	USU フ		M	RIL 4,	2006		
	8110		Casha DV	T LER	2		Greene	Stro	OU et Bai	Ihmo	re Man	pland 21201		
				32. Region 2006										

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** Stephen Hall Mobley March 29 2006 12:00 p /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster
If Under 1 Year If Under 24 Hrs. Carroll Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**№**M 2□ F Yrs. Director 217-05-3014 Usual Residence of Decedent 92 29 Aug MD the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or Iteme 23s or 28s-f ehow traumatic event, the Medical Examiner must be notified at 1 Yes 2 No MD Carroll New Windsor Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1430 Hallowell Lane 21776 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No δ Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Loyola College Accountant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be s 1 and 2 should be Heelth and Mental tem 27 is marked o Isabel Pettit 2 Roy Hall Mobley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 1430 Hallowell Lane New Windsor, MD Lucy M. Mobley/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Depertment of H
Important: If Ite
any Injury or oti 3/31/2006 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specification) Lorraine Park Cemetery Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Pritts Funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATORY FAILURE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner LOWER LOBE RIGHT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): ettending physicien and for use as the burial-transit death certificate be executed LUNG that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, RACTURE Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24a. Was an 24b. Were autopsy findings available prior to comptetion of cause of death? certificete hes performed' 2 No 2 No 1 Yes After this certification, funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner 1 Yes Other 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 0445 M 1 ☐ Yes 2 No 2 Accident Fell From standing position 3/25/06 Director 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide New Windson To the Hospital o within 24 hours eff To the Funeral DI completely filled in 1430 Hallowell Lane Home Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 7005192 (. 29b. Signature and title of certifier 2 HU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAIN STREET WESTMINSTER MD 21151 HOSAIN M.D BAST 31. Date filed (Month, Day, Year) 32. Abgistrar's Signature State APR 0 6 2006 Registrar

			1 - For State Registrar	State o	f Marylar	•	artmen rtificat				lental Hy	giene Reg. No.	006	129	68
	Physici		1. Decedent's Name (First, Middle, L. Margarita Ma								2. Date of De Month April	path Day 06	2006	3. Time of 7:55	
<i>)</i> .	/Medic Examin		4a. Facility Name (If not institution, gi		mber)		4b. City,	Town, or	Location of		· · · · · · · · · · · · · · · · · · ·		County of Death		
			Carroll Hospit		ter				nste				arroll		
	Funeral Director			Sex 1□M 2 ‡ F	7. Age (In yrs. 96	last birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 05/16	th ly, Year)	9. Birth	place (State of intry) 1ador	or Foreign
	pu a		Usuel Residence of Decedent 10a. State 10b. County		10c Ci	ty, Town or Lo	neation					,, 15		10d. Inside C	h . 1 (/a-
	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or iteme 23a or 28e-f ehow other than "natural", or iteme 23a or 28e-f ehow event, the Medical Examinal minal tenotified at	to	MD Carro	1		npstea									2 No
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	s 1 and 2 should if Health and Men item 27 ie marke other traumatic		Tina Marie Lav	rson da	ughter				Cou				, MD 2]		
٥			20a. Method of Disposition 1		State	Place of Dispo cemetery, crea	matory or o	ther place	· 1		ate		cation - City or T		
altimore,	permit. Page Depertment of Important: If ony injury or once.		4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lice		Nev	v Cath							timore, al Home		
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O. Box 6	death e etter	Physician/Me						☐Ectopic pregnancy ☐ Other (specify)					23d. Date of delivery Month Day Year		
7	res that the de signed by the e be detached f		Part II. Other significant conditions	contributing to d	eath but not res	sulting in the u	nderlying c	ause give	en in Part I.		23e. Did 1	obacco u	se contribute to	the cause of c	leath?
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Vita	sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Otho		of Death	(Check only	опе)			
	Physical direction	.: To	1 Yes 2 No 27. Manger of Death	28a. Date		ER/Outpatier			4 🗆 140		me 5 Resi		Other (Speci	fy)	
<u></u>	Attending Physician: or death. ector: After this certific by the funeral director,	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigate	(Mon	th, Day Year)	Injury	м	8c. Injury Work 1 □ \	⊲? Yes 2 🔲 I		200. 200020		00001100		
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-	4		30. Name and address of person who							ates		7	ma 1111	-17	
	Sta	te	31. Date filed (Month, Day, Year)	C. M.	CANNA legistrar's Sign	pture /	+ Pic	CE	RD	at	TMINSTA	16 1	MD 2115	7	
	Registr		APR 0 7 20	Ub Cl	que la	E GOO	We .								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician Year Ellen Virginia 6:15 P M Miller . 11, 2006 Apr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frostburg Village Nursing Home Frostburg Allegany 8. Date of Birth (Month, Day, Year) Aug. 30, 1919 West Virginia 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F Yrs. 216-72-6338 86 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Important if frem 27 is marked other then "natural", or iteme 23a or 28a-1 ehow any injury or other traumatic event. In Mental and injury or other traumatic event. 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 □ Yes 2X No Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12600 Vale Summit Road, SW 21532 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas W. Gordon Dora 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Duane A. Miller/Son 12600 Vale Summit Road, SW, Frostburg, MD 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Eglon Cemetery 4/14/2006 4 ☐ Donation 5 ☐ Other (Specify) Eglon, WV 21. Signature of Furenal Service Licensee 22. Name and Address of Facility 32 S. Second St. Butter Stewart Funeral Home Oakland, MD 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dementa Advanced 24eirs /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physicien Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Į j 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 1 Yes 1 ☐ Yes 2 🕱 No 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient Other: 4Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 Accident 5 ☐ Pending investigation 1 Yes 2 No after death filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number worsockshi 00055325 April 12,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 48 Furn Terrace Frostburg MD21532 WONSOCK MD SHIN 31. Date filed (Month, Day, Year) APR 1 8 32. Registrar's Signature State And Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 106 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year 143 AM **Physician** 2006 7116 /Medical 4c. County of Death 4b. City. Town, or Location of Death (If not institution, give street and number) **Examiner** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Canty 6. Sex Birthplace (State or Foreign Country) s. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 🂢 F Yrs 1923 Maryland 214-74-3266 Oct. Director 82 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 € No Director WV Mineral Blaine 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number P.O. Box 355 21538 United States Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
int: If item 27 is marked other than "natural; or ite 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Thomas Wilson Marguerite John ဨ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lawrence Moore, Husband P.O. Box 355, Kitzmiller, MD 21538 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 0 4/18/2006 Elk Garden, WV Kalbaugh Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility David A. Burdock Funeral Home 21. Signature of Funeral Service Licenses G. Durdock 710 Church St., Kitzmiller, MD douid 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Rugstoned minutes Physician /Medical Due to or as a consequence of): Examiner ntanschral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) 4☐Pregnant at time of death the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 4 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No ပ 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 5 Pending investigation 1 Natural 2 🗆 No 1 Yes 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide determined 4 | Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person mo 5K2

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

		4	For State Registrar	State of N	Marylan		artment of rtificate o		and Mental	Hygien Reg: N	HIII	2971
			1. Decedent's Name (First, Middle, La	ast)					2. Date Mont	of Death h Da	ay Year	
	Physicia /Medic	_	SHEILAH JOANN MO	RRIS					APRI	L 7, 2	2006	3:00 A ^M
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	₩.	đi.	CIVISTA MEDICAL		Age (In yrs.	land hirth day	LA PLA		24 Hrs. 8. Date	of Birth	CHARL	rthplace (State or Foreign
	Funeral Director			1 M 2 F	41	Yrs.	Months Day		Min. (Mon	th, Day, Year L 28, 1	7)	RYLAND
	D >		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or L	ocation					10d. Inside City Limits
	ehov	٦ ا			100.00							1 X Yes 2 □ No
	28a-f	Director	MD CHAR 10e, Street and Number	LES		WALDO	10f. Zip Cod	е		10g. C	itizen of What C	Country?
	with a se	ā	602 MARSHALL COU	IRT				20602	2	UN	ITED ST	'ATES
	ma 2;	Funeral	11. Marital Status	12. Was Decede	nt Ever in U	S. 13	Was Decedent	of Hispanic Or	igin? (Specify Yes n, Puerto Rican, et	or No-	14. Race - Arr Black, Wh	
36	d within 72 hours after death with the Maryland Jiene rithen "natural", or itema 23a or 28a-f ehow the Mudical Exercitar must be notified at	by Fur	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Force 1 Tes 2 If Yes, Give Year or Date:	□ No		1 Yes 2 X			0.7	Specify:	ACK
21215-0036	2 hou	ted	15. Decedent's 8	ducation		16a. Dec	edent's Usual Oc e kind of work do	cupation	et of working	16b.	Kind of Busines	
215	within 72 ene. then "nat	ple	(Specify only highest gi	College (1-40	or 5+)	`life.	DO NOT use re	tired)				
	filed will Hygien other th	Completed		2		ADMIN	ISTRATI			Aintella Adoido		GOVERNMENT
land	be d la la la la la la la la la la la la la	To Be	17. Father's Name (First, Middle, Las RUSSELL DUCKETT	:t)					er's Name <i>(First, N</i>		en Sumame)	
Maryland	d 2 should th and Mer 7 fs marke traumatic		19a. Informant's Name/Relationship SHIRLEY DUCKETT				•		er or Rural Route I			
	s 1 and if Health item 27 other tr		20a. Method of Disposition	TO THE	20b. F	Place of Disp	osition (Name of ematory or other	1	Date		Location · City of	
<u>ا</u>			1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		ite	-	ORIAL GAR		APRIL 13, 2	2006 WA	ALDOF. N	MARYLAND
Baltimore,	permit. Page Department of Important; if any injury of		21. Signate of Fun ral Service Lic		what	2	THORNTO	dress of Facil	KAL HOME, ON ROAD,	P.A.		
			23a. Part1. Enter the disease, or co	mplications that caus	sed the deat	h. Do not e					· man	Approximate Interval Between
201	Physician /Medical		shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	. Met	ai	tati	c Br	reas	t Cana	OND	ma	Onset and leath
	Examiner		4	Due to (or	as a consec	juence of):	tim					tout
i de	- 53°	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consec	uence of):	OC. 1)
	be executed sician and burial-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	C								
Ć.	te be executed ysician and te burial-transit	Exa	resulting in death) Last		as a consec	(uence of):						
120	# × #	cal		d								
68	rtifica ng ph	Med	IF FEMALE:			-				70.000		
.O. Box	se death certifica the attending ph	Physician/Med	23b. Was decedent pregnant in the past 12-months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknown	n 2 ☐ Feta t at time of c	al death 3	☐Ectopic pregna ☐ Other (specify				23d. Date of c Month	delivery Day Year
<u>α</u>	that the de	Ph	Part II. Other significant conditions	contributing to deat	h but not res	sulting in the	underlying cause	given in Part	i. 23e	. Did tobacco	o use contribute	to the cause of death?
Records,	50 00	d by								1 🗌 Yes	2 No 3	Probably 4 Minknown
Ö	w requir been s should	Completed							24a	. Was an	24b. Were	autopsy findings available
Re	he lav e has	E G								autopsy performed?	death	
Vital		0	25. Was case referred to medical	No.				26. Plac	e of Death Check	Trace from	10	00 22:10
>	Physician: this certific	To B	examiner? 1 Tes 2 No	Hospital: 12 Inp	atient 2	ER/Outpat	ent 3 DOA	Other: 4 🗆 N	ursing Home 5	Residence	6 ☐ Other (S)	pecify)
J of	£ = <u>a</u>		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time Injury	of 28c.	Injury at Work?	28d. Des	scribe how in	jury occurred	
Ö	Attending r death.	satle	2 Accident investigat	ho -			1	1 Yes 2				
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not determine	Zoe. Flace of	Injury - At h , etc. <i>(Speci</i>	nome, farm, ify)	street, factory, off	fice	City	or Town, Sta	and Number or ate)	Rural Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical Ce	(Check only 2 Medical Ex	Physician: To the basiner: On the basi	is of examin	owledge, de ation and/or	ath occurred at the	ne time, date a my opinion, de	and place, and due tath occurred at the	to the cause time, date a	(s) and manner and place, and d	as stated. ue to the cause(s)
	To the I within 2 To the I complete	Med	one) 29b. Signature and title of certifier	and manne	r stated.		29c. Lie	cense number		29d, [Date signed (Mo	onth, Day, Year)
	M. W. I.		A M	1.1.14		m	M		0+6	4		2006
			30. Name and address of person wh	o completed cause	of death (Ita	m 23a) (Tur		w 1 (010	-		
N	1P (0		AMIR A. MIRZA AI					ET. SIII	TE B. T.A	РТ.АТА	. MD 20	0646
N.		ate	21 Date filed (Month Day Year)	2006	istrar's Sign	ature						
	110910											

			1 - For Stete Registrer	State of Ma	aryland		artment of H		d Mental Hy	giene	106	1297	12
			1. Decedent's Name (First, Middle, Last)						2. Date of De	ath		3. Time of	Death
	Physici /Medic		Maria Asuncio	on Moi	nteagı	ıdo			April	Day 1,		2:00	\mathbf{p}^{M}
>	Examin		4a. Facility Name (If not institution, give s	street and number)			4b. City, Town, or	Location of De	eath		County of Death	1	F
			7009 Bybrook Lane	2			Chevy	Chase		M	font gome:	rv	
	Funeral		5. Social Security Number 6. Sex		e (In yrs. las	st birthday)	If Under 1 Year Months Days	If Under 24 F		rth	9. Birth	lace (State or	Foreign
	Director		577 - 70 - 2059]M 2⊠F	81	L Yrs.	Montals Days	Hours M	lin. (Month, Da March	15,19	25 Spa		
	pu		Usual Residence of Decedent 10a, State 10b, County		10- 04	T							
	shov	-				Town or Lo	cation				1	Od. Inside City	
	88a-f	Director	Maryland Worceste	er	Berl	Lin						1 🗌 Yes	2 No
	vith ti	ă	10e. Street and Number				10f. Zip Code			10g. Citi:	zen of What Cour	ntry?	
	ath v	a	25 Bridgewater Str				21811				ted Sta	tes	
	er de	Funeral		12. Was Decedent I Armed Forces?		13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? n, Mexican, Pu	(Specify Yes or No lerto Rican, etc.)	D- 1	 Race - Americ Black, White, 		
36	filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or ferms 23s or 28s-f show ant, I'le Medical Exac di set must be inclibed at	by F	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give	No		1⊠Yes 2□No	Specify:			Specify:		
8	hour ture	ed t	15. Decedent's Educ	Year or Dates:		160 Door	danie II. al O		panish		Whi		
Š	in 72 "na lectio	Completed	(Specify only highest grade	completed)		(Give	lent's Usual Occupa kind of work done of DO NOT use retired	during most of v	working	16b. Kir	nd of Business/In	dustry	
2	with ene. thar	шс	Elementary/Secondary (0-12)	College (1-4or 5	5+)		rdresser	,		Re	autv		
0	Hiled Hygi other ent, I	Ö	17. Father's Name (First, Middle, Last)			1141	urebber	18. Mother's N	Name (First, Middle				
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. In marked other than 'naturel', or frems 23s or 28s-f show the marked other than 'naturel', or frems the rediffed at eumatic event, I'm Medical Esser, it set must be rediffed at	To Be	Agapito Rojo					Maria	Cruz De	1 Hox	70		
2	should and Men a marke umatic	-	19a. Informant's Name/Relationship (Ty)	pe, Print)		19b. Mailir	g Address (Street a					Codel	
	and 2 sealth ar n 27 fe		Margarita Mendez	,			Midsummer						1878
ē,	Health tem 27 tem 27		20a. Method of Disposition	, 112000	20b. Plac	ce of Dispo	sition (Name of	1	Date		cation - City or To		070
ou	Pages nent of ont: If it		1 Burial 2 Cremation 3 R	emoval from State	cen	netery, cren	natory or other place	'	7/2006				
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Importent: if Item 27 ie marke any injury of other treumatic.		 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 		rt.		oln Crema				twood, 1		nd
Ba	permit. Page Department of Importent: if any injury or once.		May 2 (1			Ş	Name and Addres	bute Fu	ineral and	d Cre	mation (Center	
			23a Part1 Enter the disease or gorgoli	cations that caused	the death		040 Rockv				, Maryla		
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on Immediate Cause (Final	e cause on each lin	10.	201101 0111	or the mode of dying	y, such as card	nac or respiratory a	11651,		Approximate Interval Betw Onset and Di	een
	Physician /Medical		disease or condition resulting in death)	METASTA	ATIC	CAL	CER,	PRIMAR	Y UNKN	OWN			
	Examiner			Due to (or as a	a conseque	nce of):	,						
Ь		<u>0</u>	Sequentially list conditions, if any leading to immediate	Due to (or as a	a conseque	nce of).							
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
	al-tra	xal	that initiated events resulting in death) Last	Due to (or as a	a conseque	nce of):							
8760	cate be executed physician and the burial-transit	dlcal											
89		edic	- 0										
Box	the death certiff by the attending ached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome						2	3d. Date of delive	n/	
ň	atte d for	cla	in the past 12 menths?	1□Live birth 4□Pregnant at			Ectopic pregnancy Other (specify)			-	Month	-	ear
o.	the car	Jys	9 Unknown	9□ Unknown									
J.	The law requires that the ite has been signed by th bage 2 should be detache	by PI	Part II. Other significant conditions con	tributing to death bu	ut not resulti	ng in the ur	ndertying cause give	n in Part I.	23e. Did t	obacco us	e contribute to the	e cause of de	ath?
ecords,	quires n sign								1 🗆 '	Yes 2	No 3 □ Prob	ably 4 □Ur	known
Ö	w rec	Completed							24a. Was	20	24b Mara auto	au findinas au	a delie
Ϋ́ Φ	he ta e has ige 2	m C							- autor		24b. Were auto prior to cor death?	npletion of cau	use of
		CC	25. Was case referred to medical						1 ☐ Yes	2 No	1 ☐ Yes	2 🗌 No	
Vita	Physician: this certific ral director,	o Be	examiner?	ospital:	- 0055	2/0	Othe		eath (Check only o			Ho	me
Ö	Phys	-	27. Manper of Death	28a. Date of Injur		Bb. Time of	3 DOA	4 🗀 Nursing	Home 5 Resident		Other (Specify	Brothe	r's_
o	ding I h. After funer	tlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day		Injury	28c. Injury Work	? ′es 2 □ No	Lou. Doscribe	104 Injury	occurred		
Division	Attender death	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	ırv - At homi	e farm stre			28f Location (Street and	Number or Rura	Pauta Numbe	
2	after Dire	Certification;	4 Homicide	building, etc	. (Specify)	-,,	or, radiory, diffes		City or To	vn, State)	TVGITIDGE OF TIGE	riodie ivanio	3f,
	spite lours nerei		29a. Certifier 1 Certifying Phys	ician: To the best o	of my knowle	edge, death	occurred at the tim	e date and pla	ice, and due to the	cause/s)	and mannor as et	atad	
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	(Check only 2 Medicel Exeminate)	er: On the basis of and manner sta	examination	n and/or inv	estigation, in my op	inion, death oc	curred at the time,	date and I	place, and due to	the cause(s)	
	To the within To the Compl	Me	29b. Signature and title of certifier				29c. License	number		29d. Date	signed (Month, I	Day, Year)	
•	ν		· augus	mer MI)		DI	6619		An	il 5, 2		
			30. Name and address of person who co	mpleted cause of de	eath (Item 2	3a) (Tune	Print)			/			
			C.VERGARA- SOA					ACE	LANDOVE	ER	MD. 20	760	
	, Sta	te	31. Date filed (Month, Day, Year)	32. Pogistra	r's Signatur	20 4	SIGNAL PL	,	274-4000			/03	
	Registr		APR 112	006	100 h	7. A							

			1 - For State Registrar	State of Mai	•		of Health of Death		F	Reg. No.	6	129	73
П	Physicia	an	Decedent's Name (First, Middle, Last)						Date of Dea Month	ith Day	Year	3. Time of	
	/Medic		Maribel Meza					15.01	April	10,	2006	6:10	a ^M
	Examin	er	4a. Facility Name (If not institution, give s			The state of the s	wn, or Location				y of Death		
			334 East Diamond 5. Social Security Number 6. Sep		(In yrs. last birthday)		hersbur 'ear If Under		8. Date of Birt		tgome	ry lace (State o	or Foreign
	Funeral Director			M 252 F	36 Yrs.		ays Hours	Min.	8. Date of Birt (Month, Day 01/03/	, Year) L 9 7 0	Color	itry)	ir i oroigii
			Usual Residence of Decedent										
	ryland how		10a. State 10b. County		10c. City, Town or Lo	ocation					1	Od. Inside Ci	
	a-1 s	cto	Maryland Montgome	ry	Gaither	sburg							2 🗌 No
	or 28	Director	10e. Street and Number			10f. Zip Co				10g. Citizen of	What Cour	itry?	
	ath w		334 East Diamond				0877			Unite			
	tems	Funeral	T. Walter States	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decedent If Yes, specify	t of Hispanic Or Cuban, Mexica	rigin? (Spe n, Puerto	acify Yes or No- Rican, etc.)	14. Ra Bla	ice - Americ ack, White,		
36	d within 72 hours after death with the Maryland jene. Ir than "natural; or Items 23a or 28a-1 show Its Modical Examilies out be invitted at	by F	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 ☑ Yes 2 □	No Specify	Co1c	mbian	Spaci	ity: Wh	ite	
윽	P hou	ed	15. Decedent's Edu	cation	16a. Dece	dent's Usual O	ccupation			16b. Kind of 8			
212	within 72 iene. than na	Completed	(Specify only highest grade	College (1-4or 5+	life.	kind of work d DO NOT use n	fone during mos etired)	st of work	ing				
21	d with) mo	12			ber				Веа	uty		
nd	al Hygid d other event, I	Be (17. Father's Name (First, Middle, Last)						e (First, Middle,		me)		
ХIa	Ment Ment arke	2	Juaquin Meza						a Veland				
Maryland 21215-0036	2 sh and is m raum		19a. Informant's Name/Relationship (Ty			•			Al Route Numbe				
	les 1 and 2 should be filed of Health and Mental Hygie of Health and Street other is marked other or other traumatic event, II		Paulina Meza / M 20a. Method of Disposition	otner	20b. Place of Dispo				e#5; Gai	20c. Location			5 / /
20	Pages nent of int: If it		1 ⊠ Burial 2 ☐ Cremation 3 ☐ P		cemetery, cre	matory or other	r place)	/ / 1	11/2006		•		
Baltimore,		1 8	4 □ Donation 5 □ Other (Specify)21. Signature of Funera (Service License		Gate of H	2. Name and A	ddress of Facil	ity					
Ba	permit. Departr Imports eny inj	l is	1/100	_	Si	mple Ti	ribute :	Funei Pike	cal and Rockvi	Cremat	ion C	enter	352
			23a. Part1. Enler the disease, or compl shock, of heart failure. List only or	cations that caused t							1	Approximat Interval Bet	te
	Physician		Immediate Cause (Final disease or condition		ic Gastri							Onset and I	Death
	/Medical		resulting in death)		consequence of):	0_04101	ZIIOMA					_ rcar	
	Examiner	L	Sequentially list conditions,)									
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause, consease or injury	Due to (or as a	consequence of):								
	be executed sicien and burial-transit	xan	that initiated events resulting in death) Last	Due to (or as a	consequence of):								
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9	tificate I g physi as the t	ed											
Вох	eath certific attending p for use as	an/N	23b. yvas decedent pregnant	3c. If yes, outcome of 1 Live birth 2		⊒Ectopic pregr	nancv				ate of delive		Year
	it the dea by the ati tached fo	Physician/M	in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	4□Pregnant at ti 9□Unknown	me of death 5	Other (specif	fy)				Ortil	Day	i dai
P.0	that the		Part II. Other significant conditions con	atributing to death but	not resulting in the u	ınderlying caus	se given in Part	I.	23e. Did to	bacco use cor	ntribute to th	ne cause of c	death?
ds,	Se De G	d by	art in out of digital out and are the	in but ing to down but	The Cooking III will be	gonyg	o giveri iii v aii		1 🗆 Y	_		ably 4 🗀 l	
Ö	v require been si should	etec							24a. Was	an 24h	Were auto	psy findings	available
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a		e Co	25. Was case referred to medical				OC Dice	o of Doot	1 Yes	2 🖾 No	1 🗌 Yes	2 L No	
Vital	Physician: this certific ral director,	o B	eyaminer?	lospital:	t 2 ER/Outpatie	nt 3 DOA	Othor		me 5 🖸 Resid		ther (Specifi	v)	
o		n: T	27. Manner of Death	28a. Date of Injury (Month, Day			Injury at Work?	-	28d. Describe h			,	
io	를 속 찾 할	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(. dai,	М	1 ☐ Yes 2 ☐]No					
Division	for Attendated after death Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y · At home, farm, st (Specify)	reet, factory, of	ffice		28f. Location (S City or Tox	Street and Num n, State)	ber or Rura	l Route Num	nber,
	urs af		CO. C. dilina and C. dilina Ph.				to Constitution						
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical		sician: To the best of ner: On the basis of e and manner state	examination and/or in								s)
	To the To the Comple	Me	29b. Signature and title of certifier			29c. L	icense number			29d. Date sign	ed (Month,	Day, Year)	
	in		1 Moto Par	Hams		D	23308			4/10	/2006		
	5		30. Name and address of person with	mpleted cause of de	ath (Item 23a) (Type	, Print)							
	0		Victor M. Priego	, M.D. 6	420 Rock1	edge Dr	ive #4	100;	Bethesd	a, Mar	yland	20817	
	Sta Registi		31. Date filed (<i>Month, Day, Year</i>) APR 1 1 20	32/Registra	's Signature	ade							

State of Maryland / Department of Health and Mental Hygiene For Stata Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April **Physician** 10, Dinaz M. Malik 2006 1:50A. /Medical 4c. County of Death
Montgomery a. Facility Name (If not institution, give street and number) Suburban Hospital 4b. City, Town, or Location of Death Bethesda Examiner 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 7/1 | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year)
Jan. 10, 1932 9. Birthplace (State or Foreign Country) Karachi, Pakistan 5. Social Security Number **Funeral** 1 ☐ M 2 💢 F 109-44-8613 74 Yrs. Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County al Hygiene. Lother then "natural", or items 23a or 28a-f show ivent, its Mudical Examinar must be notified at 1 ☐ Yes 2X No Bethesda Maryland | Montgomery Directo 10g. Citizen of What Country? 10e. Street and Number 7505 Democracy Blvd., #127 10f. Zip Code 20817 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Never Married 2 X Married Mall Kildinaz E. R. Hilding at 0150 Baltimore, Maryland 21215-0036 1 ☐ Yes 🌠 No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <u>stats speciali</u>st 12 Insurance permit. Pages 1 and 2 should be filled w
Depertment of Health and Merital Hygies
Important: If Item 27 is marked other it
any injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dinshaw C. Minwalla (unk) Nargis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7505 Democracy Blvd.,#127 Bethesda, Maryland 20817 Noor U. Malik -husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State George Washington Cemetery 4/10/2006 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bonald Vor Borgwardt Funeral Home, PA 21. Signature of Funeral Service Licensee 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hypercarbic / Hypercarbic /Medical Due to (or as a consequence of) Examiner COPD S. rentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit or Attending Physicien: The law requires that the deeth certificate be executed Interstikal 343.95.10 resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Bronchiec fasis been si should l 24a. Was an autopsy performed? 1 ☐ Yes 204 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Anemia certificate : After this certifica e funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification; To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation Natural efter death.

Director: Aft d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours efter de To the Funeral Directo completely filled in by th 4 Momicide To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 4110106 1000 62176 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hossein Akhondi-Asl, M.D. 8600 Old Georgetwon Road Bethesda, Maryland 20814 31. Date filed (Month, Day, Year) APR 11 32. Rigistrar's Signature State 2006 Registrar

			1 - For State Registrar	State of Ma	aryland		artmen tificate					giene Reg. No.	06	12975
	Physicia	an	Decedent's Name (First, Middle, Last								2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic	al		MOULT	04		4b Cib.	Town, or I	Lasatina	of Dooth	04	09	unty of Death	0400 AM
	Examin	er	4a. Fecility Name (If not institution, give		2000	inh	46. City,	link	111A	J M	10 2180	1 / 1	1 .	mico
_	Funeral		5. Social Security Number 6. S	CULSING 2	(In yrs. las	t birthday)	If Under			24 Hrs.	8. Date of Bir	th		nplace (State or Foreign
	Director		126-10-9048	□ M 2004	90	Yrs.	Months	Days	Hours	Min.	(Month, Da	1915		York
	pu .		Usuel Residence of Decedent 10a. State 10b. County		10c. City, 1	Town or Lo	cation					Mit -		10d. Inside City Limits
	Aaryla f eho	٥	Maryland Wicomic	20	,	isbur								1 Yes 2 No
	28a-	rect	10e. Street and Number				10f. Zip	Code				10g. Citizer	of What Cou	untry?
	a within 72 hours after death with the Maryland piene. r than "naturel", or Items 23a or 28a-f ehow If a Medical Exactinar must be notified at	by Funeral Director	105 Times Square	•				2180)1			US	A	
	ems s	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. \	Was Deced	ent of His	spanic Oi	rigin? (Spe	ecify Yes or No Rican, etc.)	- 14.	Race - Amer Black, White	
9	hours after lural', or Ite	y Ft	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🖾 Divorced	1 ☐ Yes 2X N If Yes, Give Year or Dates:	10		I □ Yes		Specify					nite
2-0036	hour	ed b	15. Decedent's Ed			16a. Deced	lent's Usua	I Occupa	tion			16b. Kind	of Business/l	ndustry
5	nin 72 in "na	plet	(Specify only highest gra			(Give life. I	kind of wor DO NOT us	rk done di se retired)	uring mos	st of worki	ng			•
7	e filed within 72 al Hygiene. other than "nal	Completed	Elementary/Secondary (0-12)	- 0		Sean	stre						arment	
yland		Be	17. Father's Name (First, Middle, Last)								(First, Middle,	Maiden Su	mame)	
-	2 should be and Mental le marked raumatic ev	ဥ	Richard Dutcher 19a. Informant's Name/Relationship (7)	Tune Print)		10b Mailir	a Addrose	(Stroot a)			ennett Il Route Numb	ar City or Ti	our State 7	in Cada)
Z	s 1 and 2 should f Health and Mer item 27 le marke other traumatic		Donald D. Moulton	*			-				Parson	-		
ē,	s 1 and if Health item 27 other tr	-	20a. Method of Disposition		20b. Plac	e of Dispo	sition (Nan	ne of ther place	1		Date	20c. Locat	ion - City or 1	fown, State
Ē	Pages nent of ant: If it		1 ☐ Burial 2 🖾 Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify			sbury	•	•		4/10	/06	Sali	sbury,	MD
Baitimore,	permit. Pages 1 a Department of Hea Importent: If Ifem eny injury or othe		21. Signature of Funeral Service Ucer	ine (F	SP	22	H8717 501 S	d Address Snow	fune Hill	ral Rd.	Home Pr , Salis	ofess	ional MD 21	Association 804
7	77 (4)		23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plication that caused one cause on each tir	the death.	Do not ent	er the mode	e of dying	, such as	s cardiac o	or respiratory a	rrest,		Approximate Intervat Between
	Physician		Immediate Cause (Final disease or condition	a. /	(scv)									Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as										
		-	Sequentially list conditions,	b. — Due to (or as		ve nh	4							
	uted d ansit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events											
oʻ	an an		resulting in death) Last	Due to (or as	a consequer	nce of):								
7 9 7 9	death certificate be executed attending physician and of for use as the burial-transit	Ical		d										*
ō	leath certifica attending pl	Physician/Med	IF FEMALE:	23c. If yes, outcome	of prognance									
X Q Q	eath c attend for us	slan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at	2 Fetat de	eath 3	Ectopic pro					230	. Date of delive Month	very Day Year
o.		yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	timo or dod.	5	201161 (30							
, , ,	law requires that the as been signed by th 2 should be detache	by Pi	Part II. Other significant conditions of	ontributing to death b	ut not resulti	ng in the u	nderlying ca	ause give	n in Part	I.	23e. Did t	obacco u <i>s</i> e	contribute to	the cause of death?
ecords,	w requires that been signed t should be deta										1 🗆 '	Yes 2□N	lo 3∏Pro	babiy 4 Unknown
ပ္ပ	e law re has be je 2 sho	plet									24a. Was		4b. Were aut	opsy findings available ompletion of cause of
r	Th ate pag	Completed									perfo 1 ☐ Yes	rmed?	death? 1 🗌 Yes	2 1 No
VITA	sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner?	Hospital:			-	Othe	111111111111111111111111111111111111111		(Check only o			
0	Phyer this ral dir	. To	1 ☐ Yes 2 ☐ No 27. Manper of Death	28a. Date of Inju	v 28	VOutpatien 8b. Time of		JA	4 N		me 5 Resi			ify)
0	th. : After s funer	ıtlor	1 ☑Naturat 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	í Year)	Injury	м	8c. Injury Work 1	? ′es 2 🗀					
DIVISION	or Attending Physician: Ifter death. Director: After this certific in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of tnji	ury - At home	e, farm, str	eet, factory	, office		1	28f. Location (: City or To		lumber or Rui	ral Route Number,
5	itel or irs afti rel Dii led in													
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical	29a. Certifier 1 ☐ Certifying Ph (Check only 2 ☐ Medical Exan	ysicien: To the best niner: On the basis of and manner sta	examination	edge, death n and/or in	occurred a vestigation,	at the time , in my opi	e, date a inion, de	nd place, a ath occurr	and due to the ed at the time,	cause(s) an date <i>a</i> nd pla	d manner as ace, and due	stated. to the cause(s)
	To tha within 2 To the Complet	Med	29b. Signature and titte of certifier				290	. License	number			29d. Date s	igned (Month	, Day, Year)
	18		▶ Num					347	0644			4	191	06
	29		30. Name and address of person who	completed cause of d	eath (Item 2	За) (Туре,	Print)		,			Λ	11 21	80 14
	(1)		31 Date filed (Month Day Year)	ESAN 32 Maistr	ar's Signatur	1415	5.0	1 V/5/6	W S	TREEL	74U 31	70129	www a	/
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 1 2	completed cause of d	w d	k A	seals)	,						

			For State Registrar	State	of Ma	ryland		artment of H tificate of				giene Reg. No.	006	12976
	Division		1. Decedent's Name (First, Middle								2. Date of Dea	ath Day	Year	3. Time of Death
	Physici /Medic			Rita	a B.	Myer	îs				April	7	2006	4:55 P M
	Examin		4a. Fecility Name (If not institution		,			4b. City, Town, o	or Location	n of Death		4c.	County of Death	
T			4409 Cross Cou					Elli∞					Howard	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 21X F		, ,	st birthday) Yrs.	If Under 1 Year Months Days		er 24 Hrs. Min.	8. Date of Birt (Month, De	h y, Yeer)	Cou	place (State or Foreign intry)
30/2	Director		216 26 7139 Usual Residence of Decedent		66		113.				Sept 1	5, I	939 Mai	ryLand
	and and		10a. State 10b. County			10c. City,	Town or Lo	cation						10d. Inside City Limits
	Mary feb	Ö	MD Howa	rđ		F11	icott	City						1 ☐ Yes 2√2 No
	the 28a	Director	10e. Street and Number	La	1	ال عالية	.10000	10f. Zip Code				10g. Citi	zen of What Cou	intry?
	3a or	D	4409 Cross Cou	otra Dria	70			210	12			Un	ited Sta	tec
	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Itama 23a or 28a-f ehow event, the Medical Examinat man be notified at	Funeral	11. Marital Status	12. Was De	cedent E	ver in U.S	S. 13. \	Vas Decedent of I	tispanic (Origin? (Sp	ecify Yes or No		14. Race - Amer	ican Indian,
٥	or Ita		1 ☐ Never Married 2 ☐ Marri	ed 1 ☐ Yes	2 X N	0		Yes, specify Cub			Hican, etc.)		Black, White	, etc.
3	hours after tural', or Ita	by	3 Widowed 4 Divorced	If Yes, G Year or				I□Yes 2☐xNo	Specif	ry:			Specify: Wh	ite
9500-91212	72 hc natur	Completed	15. Decedent (Specify only highes)			lent's Usual Occup		ost of work	ina	16b. Ki	nd of Business/Ir	ndustry
7	within 72 ene. then "nai	np(Elementary/Secondary (0-12)	College			life. I	DO NOT use retire	nd)				tgomery	
	filed w Hygier other th	ပို	12				Purch	asing Ag					eral Hos	spital
and	be filed htal Hygie od other event, I	Be	17. Father's Name (First, Middle,	,							(First, Middle,	Maiden	Sumame)	
>	Mer Mer stic	T0	August P. Balsa								raguilo			
Mar	CA 42 - 44	11	19a. Informant's Name/Relations! David Myers/Hu:					Grade Co						р Соде) MD 21043
	s 1 and f Health item 27 other tr		20a. Method of Disposition	50a11a		20h Pla		sition (Name of	Juilu		oate		cation - City or T	
Ö	Pages nent of h int: If ite		1 Burial 2 Cremation		State	CO	metery, cren	natory`or other pla	ce)					
altimore,	ntmer rtent rtent njury		 4 □ Donation 5 □ Other (S) 21. Signature of Funeral Service 			-		ematory	on of Fac				onsville	
g	permit. Pages 1 Department of H importent: If ite eny injury or ott		SILV SIGNALITY OF PURPORAL SOLVICE	1100	. 1	40104	.4		7-7	""Harr	y H. Wi	tzke	e's Fami	ly FH Inc.
			23a. Part1. Enter the disease, or	complications that	caused	the death.							et City,	MD 21043 Approximate
			shock, or heart failure. List Immediate Cause (Final	onty one caluse on	each lin	e. 		RTERY			_			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	OKO	Conseque	1 1	KILLY	1019	1613				5 YEARS
	Examiner			E Due II	(Ur as a	Consequ	ence or).							
Е		er	Sequentially list conditions, if any, leading to immediate	b. — Due to	(or as a	conseque	ence of):					· · · · · · · · · · · · · · · · · · ·		
	uted d ansit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
))	an an rial-tr		resulting in death) Last	Due to	(or as a	conseque	ence of):			· · · · · ·				
9/8	The law requires that the death certificate be executed ite has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical		d										
9	ng ph	Med	IF FEMALE:											
X Q R	ith ce tendi	an/I	23b. Was decedent pregnant	23c. If yes, o 1☐Live		of pregnan 2 Fetal o		Ectopic pregnanc	у			2	23d. Date of delive	rery Day Year
	at the death certif by the attending tached for use as	Sici	in the past 12 months? 1 ☐ Yes ②☐ No	4□Preg 9□Unk		time of de	eth 5□	Other (specify)					MOHUT	Day 19ai
J Ö	d by letach	Completed by Physician/Me	9 Unknown	se contributing to	doath bu	t not recul	ting is the w	adorhijog opuse gu	on in Par	+ I	23a Did to	abacco u	sa contributa to	the cause of death?
Š,	w requires that been signed b should be deta	by	Part II. Other aignificant condition	MB	بالسل	TUS	ung in the o	idenying cause gr	ven in rai	t I.		es 2[~1
Kecords,	requ	eted	CEREBR	NIA CON	M	\\	GACG				-			
ပ္	e 2 s	npi	CUCICOR	JAIJ 2CAL	MIC	1/1/1	1013 2K				24a. Was autop	an sy rmed?	24b. Were autoprior to condeath?	opsy findings available empletion of cause of
=		Co		· · · · · · · · · · · · · · · · · · ·								2 No	1 Yes	2 N 0
Vital	nysicien: The law nis certificate has t I director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:				0#			(Check only o		-	
0	Phys this a	T.	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1			R/Outpatien	t 3☐ DOA O" 28c. Inju					Other (Speci	(fy)
	ing I	ion	1 Natural 5 ☐ Pendin		nth, Day	Y <i>eer)</i>	28b. Time of Injury	Wo	rk?]Yes 2[28d. Describe h	iow injur	y occurred	
<u>s</u>	death death ctor: / the	ical	2 Accident investig	ot be	e of Iniu	rv - At hor	me farm str	eet, factory, office	,,,,,,		28f. Location //	Street and	d Number or Rur	al Route Number,
Division	tal or Attending Pt s after death. el Director: After tt ed in by the funeral	Certification:	4 ☐ Homicide determ	ned buil	ding, etc	. (Specify)	, , , , , , , , , , , , , , , , , , , ,	301, 140101y, 011100			City or Tox			
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 🔀 Certifyin	g Physicien: To th	ne best o	f my know	rledge, death	occurred at the ti	me, date	and place.	and due to the	cause(s)	and manner as	stated.
	e Ho	Medicai	(Check only 2 Medical one)	Examiner: On the	basis of nner stat	examination	on and/or inv	estigation, in my o	opinion, d	eath occurr	ed at the time,	date and	place, and due t	to the cause(s)
	To the within 2 To the Complet	Me	29b. Signature and title of certifier	+ MA	10			29c Licens	se numbe	[0		29d. Date	e signed (Month,	Day, Year)
			> Man	1 / J W)		1.10	770)9		Anr	il 8, 2	006
\ n ²	2		30. Name and address of person	who completed car	use of de	ath (Item	23a) (Type,	Print)	-	•			0, 2	
) "			Dr. Scott Maue					lo Glenwo	ood,	MD				
	Sta	te	31. Date filed (Month, Day, Year)	32.	Regiona	r's Signati	шгө	1						

		-	For State of Maryla 1 - State Registrer	•	artment of He			ne 006	12977
	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
· Ji	/Medic	al	John Francis Monaco 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or I		Apr. 3	2006 4c. County of Dear	10:10a ^M
	Examin	er	Chesapeake Hospice House	e		thicum		,	Arundel
	Funeral		5. Social Security Number 6. Sex 7. Age (In)	rs. last birthday)		If Under 24 Hrs. 8 Hours Min.	B. Date of Birth (Month, Day, Y	ear) 9. Birt	hplace (State or Foreign ountry)
	Director		577-18-0385 Superior Street St	7 Yrs.			Dec. 25,	1918 Was	hington, DC
	Maryland -f show lied at	tor	10a. State 10b. County 10c. MD Anne Arundel 10c.	. City, Town or Lo	cation Annap	∞lis			10d. Inside City Limits 1 Yes 2 No
	with the 3a or 28a If be not	Funeral Director	10e. Street and Number 933 Edgewood Road, Apt. 215		10f. Zip Code 21403	3	10g	. Citizen of What Co	ountry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hygiene. Department of Heelih and Mental Hygiene. Since and the stranger of the stranger o	þ	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced 12. Was Decedent Ever in Armed Forces? 1 XF yes 2 No If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cuban 1 ☐ Yes 2 ☑ No		ify Yes or No- ican, etc.)	14. Race - Ame Black, Whit Specify:	
21215-0036	ithin 72 ho le. len "natur Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occupat kind of work done du DD NDT use retired)	uring most of working	7	b. Kind of Business	·
N	filed w Hygier other th		11 17. Father's Name (First, Middle, Last)		Master Pl	umber 18. Mother's Name (overnment
Maryland	Aental Aental rked o	To Be	Patsy Monaco			Anna Car			
lary	2 should have and have la man		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street ar			-	
	ts 1 end 2 of Heelth a Item 27 le other trac		Darlene Monaco/Daughter 20a. Method of Disposition 20	b. Place of Dispo	Longfello sition (Name of	Da		C. Location - City or	21108 Town, State
MO	Pages nent of int: If It iny or o			rinity Men	natory or other place portal Garden	ns Apr 20	1 300	Waldorf, N	MD
Baltimore,	permit. Departn Imports sny Inju		21 Ignature of Funeral Service Litens to	mo	l95 Gov. R	o Soms, P. itchie Hw	A. Sever y, Sever	na Park F na Park,	uneral Home MD 21146
	Physician		23a. > n1. E ter the disease, or complications that caused the content of shock, or heart failure. List only one cause on each line. Immediate C use (Final disease or condition resulting hideath)	path. Do not ent	in the mode of dying	such as cardiac or	respiratory arres		Approximate Interval Between Onse, and Death
	/Medical Examiner	1	Due to for any con	sequence of):	isan				centrum
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	sequence of):					
8760,	sate be executed physicien and the burial-transit	Ical Ex	resulting in death) Last Due to (or as a condition of the condition of th	sequence of):					
9	entifica ing ph e as th	Med	IF FEMALE:						
O. Box	that the death certific ed by the ettending pi detached for use as t	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
rds, P.O.	S 5 0	ρ	Part II. Other significant conditions contributing to death but not	resulting in the u	nderlying cause give	n in Part I.	23e. Did toba		the cause of death?
Vital Records,	The law require ste hes been sig pege 2 should b	Completed			J		24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
/ital		Be C	25. Was case referred to medical examiner?			26. Place of Death		Cŧ	LESAPEAKE
o	Jing Ph J. After th funeral	atlon: To		2 ER/Outpatier 28b. Time of Injury	f 28c. Injury Work	4 Nursing Hom	e 5 Resident 3d. Describe how		HOYSE
Division	s after de s after de al Directo ad in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - J building, etc. (Sp		eet, factory, office	28	Bf. Location (Stre City or Town,	et and Number or Ri State)	ural Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier (Cneck only one) Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examiner and manner stated.	knowledge, death	h occurred at the time vestigation, in my opi	e, date and place, ar inion, death occurred	nd due to the cau d at the time, date	se(s) and manner as and place, and due	s stated. to the cause(s)
	To t withi To tl comp	W	29b. Signature and title of certifier Whal J J.	en Aqu	p 29c. License			Date signed (Mont	
			MICHAEL J. LAPEN	(Item 23a) (Type,	Print) 445 [EFENSE	HIGHWI	ay Anna	03 2006 ous mouro,
	Sta Registi		31. Date filed (Month, Day, Year) 32. Repistrar's S	ignature	boll .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month 12 Physician 2006 1:55 PM Morgan eonard /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Worceste Berlin Atlantic General Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Jun. 9, Birthplace (State or Foreign Country)

MT 7. Age (In yrs. last birthday) **Funeral №** M 2 F 65 MD 220-36-2651 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State ir then "natural", or Iteme 23a or 28a-f ehow Ite Medicul Exercices cost be notified at MD Worcester Berlin 1 ☐ Yes 2X No Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 208 Windjammer Road 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No 195 If Yes, Give Year or Dates: 195 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1957-1 Never Married 2 Married White Maryland 21215-0036 1 ☐ Yes 2 X No Specify þ 3 ☐ Widowed 4 🎖 Divorced 1959 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 1 and 2 should be filed within Health and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Self-Employed Carpenter 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lawerance Reds Morgan Edna Rosa Minnick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 36 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2
Tent of Health ar
nt: if item 27 is 1. Robin Marie Flewellyn/Daughter 1028 Stonington Drive, Arnold, MD Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Apr. 2006 1 🔀 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: if eny injury or pncs. MD Veterans Cemetery Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Senature of Puneral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Chronic obstructive pulmonary disease months **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 9☐ Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Metastatic aderocarcinoma with 1 Pres 2 No 3 Probably 4 Unknown carcinona & primary 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 2 3 10 Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification; Division Hospital or Attending 1 Natural 5 Pending investigation efter death.

Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours of To the Funerel D completely filled i 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number (DE) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier C1-0006795 4-3-06 Kusting Sleygen, MD 30. Name and address of person who completed se of death (Item 23a) (Type, Print) KRISTINE GRIFFIN, MO 1209 COASTAL HIGHLAY, FENUICK ISLAND, DE 19944

Registrar

31. Date filed (Month, Day, Year)

APR 0 7 2006

ORIGINAL

32. Redistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year 8:50 P M April 2, 2006 Alvin Richard Maier /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel Il Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1**X** M 2□ F Yrs. Director May 26, 220-28-5994 72 1933 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Evandmentmed by notified at 1 Tyes 2 No Directo Davidsonville Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21035 3466 Godspeed Court USA Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1953–55 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Building Materials other than Elementary/Secondary (0-12) College (1-4or 5+) and Supplies 2 years Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked o Elsba Pullman Ernest Maier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bette L. Maier/ Wife 3466 Godspeed Ct., Davidsonville, MD 21035 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal Irom State 4 ☐ Donation 5 ☐ Other (Specify) 4-8-06 Lakemont Meml. Gardens Davidsonville, MD 21. Signature of Faneral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home any ir Ma 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician at s the burial-t Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed? page certificate 2 🔯 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 🗓 No 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After t 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director; 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified Mustra. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Island Rd Annapolis, uno 21401 Keith Damsker

31. Date liled (Month, Day, Year) 139 old Solumons 327 Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

APR 0 7 2006

			1 - For State of Maryland / Departme Registrar Certifica	nt of Health and M te of Death		2000 0 6	12980
Ĺ			1. Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	3. Time of Death
F	Physici /Medic		Robert Enoch Munro		April 8		20:26 M
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. Cit Anne Arundel Medical Center	y, Town, or Location of Death Annapolis		4c. County of Death Anne Arr	undol
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Und	er 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Y		place (State or Foreign
	Director		228-05-2818 TAM 20 F 88 Yrs.	s Days Hours Min.	Nov. 16	, 1917 Vii	rginia
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	ith the	Director	10e. Street and Number 10f. Z	ip Code	100	g. Citizen of What Cou	ntry?
	23a		5106 Holly Drive	20778		USA	
	tems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Dec	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
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d)	t and Health tem 27 other to		20a Method of Disposition 20b. Place of Disposition (N	ame of		Oc. Location - City or To	own, State
S E	Pages ent of nt: ff i		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	n Crematory 04	L-10-06	Alexandria	, VA
Baltimore,	permit. Pages 1 Department of H Importent: If ite any Injury or ot		21. Signature of Euneral Service Licensee 22. Name	and Address of Facility			
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	To the To the Comp	Me	29b. Signature and title of certifier	9c. License number	290	d. Date signed (Month,	Day, Year)
			William & formo	D06054		4/10/	6
(8+1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	131 Shade	side	Rd 2	0724
	Sta Registr		29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day 19ac) 32. Registres Signature 1 1 2 005	and a		1	
100	negisti	al .	Jacobs Jo. Jags				

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Mar	and and series		19a. Informant's Name/Relation	ship (Type, Print)		19b. Maili	ing Address (Street	and Number or	Rural Route Num	ber, City o	r Town, State, 2	Zip Code)
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	Physici	an	1. Decedent's Name (First, Middle, Las								2. Date of Dea Month	ith Day		3. Time of Death
	/Medio		Leroy Nichelson 4a. Facility Name (If not institution, give		er)		4b. Cit	y, Town, or	l ocation (of Death	April	1	2006 County of Death	6:15 A ^M
	Exami	iei	4305 Kinmount		,		40. OIL	y, 10411, 01	Lanh			40.		George's
	Funeral		Social Security Number 6. S	9x 7.7	Age (In yrs.	last birthday)	If Und Month	er 1 Year s Days	If Under Hours		8. Date of Birtl (Month, Da)	h (Year)		nplace (State or Foreign
	Director		378-30-0936	∆M 2□F	67	Yrs.	INOTHI	Days	riours		Feb. 22			th Carolina
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
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	th the	Director	10e. Street and Number	occipe b			10f. Z	Cip Code	aman			10g. Citiz	zen of What Co	untry?
	within 72 hours after death with the Maryland one. than "natural", or items 23a or 28s-f ehow ha Madical Ezain, or initial be collified at		4305 Kinmount						2070				nited S	tates
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7	iled v Hygiel Ither th		17. Father's Name (First, Middle, Last)	4		Cc	mput	er P			(First, Middle,	44-7-1	Govern	ment
ylallu	d be f	o Be	James Ga	ston					18. MOLITE	en s ivame			chelson	
<u> </u>	2 should be filed volume and Mental Hygie is marked other traumatic event, in	5	19a. Informant's Name/Relationship (7			19b. Mailir	ng Addre	ss (Street a	and Numbe	er or Rura			Town, State, Z.	ip Code)
Ž	es 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. 19 Health and Mental Hygiene 19 filem 27 is marked other than "natural", or items 23a or 28s-1 show it enter traumatic event, the Medical Evant, est must be collised at a other traumatic event, the Medical Evant, est must be collised at		Yusuf Ali/Bro	ther			4835	Lee	St.,		Wash.			
ย	of He of He if item		20a. Method of Disposition 1 XBurial 2 Cremation 3 C	Removal from Stat	20b. P	Place of Dispo emetery, crer	sition (N	ame of other place	em.	D	ate	20c. Lo	cation - City or 1	Town, State
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5	ath. r: Afte e fune	atioi	1 ♣Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, L	Day Year)	Injury	М		(? Yes 2 □ I	1		,,		
DIVISION	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral	ertification:	3 Suicide 6 Could not be 4 Homicide determined	286. Place of I	njury - At ho etc. (Specify	ome, farm, str	eet, facto	ry, office		2	Bf. Location (S City or Tow	treet and n, State)	Number or Rui	ral Route Number,
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JH	- 3		30. Name and address of person who	-			,							
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ORIGINAL

DHMH 17 Rev 1/2001 •-

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Certificate of Death	Reg No	2006	1298	,
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			1- For State Registrar	ate of Maryland	•	ificate of				g No. 200	6 12983
Phys		n/	Decedent's Name (First, Middle	,Last)	·				Date of Deat Month		3. Time of Death
edical Exa	amir	ner		ROSALIE	NORM	AN			April 12, 20	006	0510 hrs
			4a. Facility Name (if not institution	, give street and number)	4	b City, Town, or Loc	ation of Death	ı	4c. County of Dea	
			Doctor's Hospital				Lanham			Prince Georg	
Fune: Direct					ge (In yrs. las	(1		f Under 24Hrs Hours Min		h(MM/DD/YYYY) 9. E Fore	ign
Direct				1 M 2X F		61 _{Yrs.}			Jun 1	6 1944	ountry) Ohio
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ryland a-f sh	1 0110	흱	10e. Street and Number	- 300160	1 20 %		10f. Zip Code			g Citizen of What Co	
after death with the Maryland "al", or items 23a or 28a-f sho	be notified at once.	Director	15808 Pinec	roft Lane			20716			U.S.A	
vith th	noti		11. Marital Status	12. Was Decedent	t Ever in U.S	13 Was	Decedent of Hispan		pecify Yes or No-		erican Indian, Black,
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5-0 led w Hygid	the	- 1	17. Father's Name (First, Middle, I	Last)			1		(First, Middle, M	,	
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Should Mind Mind Mind Mind Mind Mind Mind Min	atic	유	19a. Informant's Name/Relationsh		. 1	19b. Mailing	Address (Street an	nd Number or F	Rural Route Num	ber, City or Town, Sta	te, Zip Code)
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene Important: If item 27 is marked other than "matural", or iter		-	Michael L. No.	orman, nus			tion (Name of cemete		Date Date	20c. Location - City	
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Ball Dermit	- În		21. Signature of Firm ral Service L	iceni Wainda C.	on on						NERAL HOME
		-	23a Part I. Enter the disease, or o	complications that caused	d the death I						ngton D.C. Approximate Interval
Physici /Medic			failure. List only one cause of	on each line.			347			st, shock, of fleat	Between Onset and Death
xamin	er	Ì	Immediate Cause (Final disease or condition resulting in death)	a <u>Cardiac</u> Al			myocardial	filmsis	3		Deatri
*			Sequentially list conditions,	b.	requerioe or,						
		ē	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cons	sequence of)	:					
	-	Examiner	(Disease or injury that initiated	c. Due to (or as a cons	equence of						
uted	- transit		events resulting in death) Last	d		•					
e execute	ial - tr	/Medical	Xunpended	X AMENDED i	ten#23a	,27 perM ,perFH,G	5,8855,5/15/	PF TT			
760, ficate be ex	the burial	Me	IF FEMALE:	23c. If yes, outco			523,3/23/00	11		23d, Date of delive	ery
			23b. Was decedent pregnant in the past 12 months?	Live birth			al death 3 E	Ectopic pregna	ancy	Month	Day Year
Box 68 death certif	for use as t	Sic	1 Yes 2 No 9 V Unkr		t time of dea	th 5 Oth	er (Specify)				
ш ; е	귯	Physician	Part II. Other significant condition	The second secon	th but not res	sulting in the ur	nderlying cause giver	n in Part I	23e Did to	pacco use contribute t	o the cause of death?
P.O.	dete	ρ		· ·			, , , , , , , , , , , , , , , , , , ,		1 Yes		obably 4 🗸 Unknown
ds, equire	should b	Completed							24a Was a	n 24b. Were a	autopsy findings available
cords law requested bas been	2 sh	ğ							autops perfor		completion of cause of
tal Rection: The	, pag	S							1 Y Yes 2		
ision of Vital Records, Attending Physician: The law requir T death Peters: After this certificate has been s	rector	Be	25. Was case referred to medical examiner?	Hospital:			- Oth	Death (Check			
of Vi Physic er this	ral di	리	1 Yes 2 No	Hospital: 1 Inpatie		ER/Outpatient 28b. Time of In				Residence 6 Oth	er:
on of Iding Pl		Ö	1 X Natural 5 Pendi	(Month, Day,)	Year)	200. Time of its	1 Yes		200. Describe i	ow injury occurred	
Division tal or Attendir rs after death	by the	Certification:	2 Accident Invest	tigation 28e Place of Ir	niury - At hor	me farm stree	, factory, office build		28f Location (S	troot and Number or E	Rural Route Number, City
Divis		Ę	deterr	not be (Specify)	njury - Acrioi	ne, raini, suce	r, ractory, office pullul	iirig, etc.	or Town, St		tural Route Number, City
Divi Hospital or 24 hours afte	ıly fill		4 Homicide 29a. Certifier 1 Certifying Ph		ny knawlada	o donth goguer	ad at the time, date a	and place and	due to the second	-/->	and a
D To the Hospital within 24 hours To the Funcral	completely	Medical		ysician: To the best of m niner:On the basis of exa	amination an						
70 Kit	COL	Mec	29b Signature and title of certifier	and manner stated			29c. License nu	umber		29d Date signed (M	onth, Day, Year)
			auat)	are.			O.C.M.E	Ξ.		April 14, 2006	
^			30. Name and address of person	who completed cause of	death (Item 2	23a)					
CF	-			istant Medical Exar			treet, Baltimore,	MD 2120	1		
	St	ate	31. Date filed (Month, Day, Year)	32. Registra	ar's Stratur	· hade	,				

DHMH 17 Rev 1/2001

ORIGINAL

		•	For State Registrar	State of Marylan		artment of H <i>rtificate of L</i>		ental Hygiei Reg.	21116	12984
	D1		1. Decedent's Name (First, Middle, Las	")				2. Date of Death Month	Day Yeer	3. Time of Death
	Physicia /Medic		SEYMOUR			NAGH	911	MARCH	28,200	6 12:18 PM
	Examin Funeral Director	er	4a. Facility Name (If not institution, give THE SOMUS HO 5. Social Security Number 6. Se 120-18-5776	OKINS HOSPI		4b. City, Town, or BAIH	MORE () If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Dec. 18,	Baltimo Baltimo 1920 Ne	
	ס		Usual Residence of Decedent							
	arylar ehow	-	10a. State 10b. County Maryland Montgome		n, Town or Lo hevy C					10d. Inside City Limits 12 Yes 2 No
	28a-f	ectc	10e. Street and Number			10f. Zip Code		100	Citizen of What C	
	Mith with	ā	4701 Willard Aven	ue, # 603			815	log.	U. S. A.	•
21215-0036	be filed within 72 hours after death with the Maryland all Hygiene. And Hygiene of the than "neturel", or terms 23a or 28a-f show event, the Madical Examinar must be notified at	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2∑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2X No	spanic Origin? (Spec n, Mexican, Puerto P Specify:	ify Yes or No- lican, etc.)	14. Race - Am Black, Whi	
2-0	72 ho	eted	15. Decedent's Edi	ucation de completed)	16a. Dece	dent's Usual Occupa	tion uring most of workin	a 16b	. Kind of Business	/Industry
21	within ene. then.	mple	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	life.	DO NOT use retired) ournalist	July 11 out of 11 of 11		Priva	+ 6
	e filed within al Hygiene. other then vent, in Me		17. Father's Name (First, Middle, Last)	3+	3.0	Julharist	18. Mother's Name	(First Middle Maid		
aŭ	ld be ental ked o	To Be	Arthur Nagnowitz				Anna Ja		,	
Maryland	s 1 end 2 should if Health and Mer item 27 is marke other traumatic	-	19a. Informant's Name/Relationship (7) Gloria M. Nagan				nd Number or Rural Avenue, #			Zip Code) , Md. 20815
Baltimore,	permit. Pages 1 end Department of Heati Importent: # item 2 any injury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State Nat	emetery, crer ional	osition (Name of matory or other place Crematory	4-3-20	006 Fa		ch, Virginia
Bai	permit Depar impor any in		21. Signature of Funeral Service Licens	Stottlemy	ا سعا	1170 Rocky	Goldberg ville Pike	, Rockvi		
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. INTRAOPE	SRAF		g, such as cardiac or			Approximate Interval Between Onset and Death 2 HOURS
	Examiner	_		b. Due to (or as a consequence of the consequence o	EIN	FYJUR	y			2 HOURS
68760,	icate be executed physicien and s the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Pue to (or as a consequ	4 OF	PAMER	EAtic	Tumor	2	3 HOURS
_	Ξ ⊘ α ∣	Med	IF FEMALE:	,						
P.O. Box	thet the death certified by the attending detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna. 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
	8 5 g	ρ	Part II. Other significant conditions co					23e. Did tobacc	1.	o the cause of death? robably 4 ∐Unknown
Vital Records,	The law ete has b page 2 si	Completed						24a. Was an autopsy performed 1 Yes 2	? prior to death?	utopsy findings available completion of cause of s 2 No
Vita	Physician: The this certificate ral director, page	Be	25. Was case referred to medical examiner?	Hospital:		Othe	26. Place of Death			
ō	Phys this ral dia	2	1 Yes 2 No 27. Vanner of Death	28a. Date of Injury	ER/Outpatier 28b. Time of	II 3 DOA	4 Nursing nom	e 5 Residence		icity)
ion	Attending P ir death. actor: After i by the funera	atlor	1 □Natural 5 □ Pending 2 ☑ Accident investigation	0.9/98/8006	Injury 10.00		? 'es 2 No 2	MARICA	Pana	EDI IOI
Division	Attendi	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me farm str		21	Bl. Location (Street City or Town, St	and Number or R	ural Route Number.
Õ	rs after or rai Dia			THE JOHNS 1	JOPKI,	NS HOSP	ITAL 6	00 N. WOL		HIMORE, MD
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	(Check only 2 Medical Exam	sician: To the best of my know iner: On the basis of examinat	wledge, death ion and/or in:	h occurred at the tim vestigation, in my op	e, date and place, ar inion, death occurre	nd due to the cause d at the time, date a	(s) and manner a and place, and du	s stated. e to the cause(s)
	ithin 2 o tha	Med	29b. Signature and title of certifier	and manner stated.		29c. License	number	29d.	Date signed (Mon	th. Dav. Year)
	β ∓ ξ + I)(T		700	56884	m	ORALL 10	2000
	(10)		30. Name and address of person who c		23a) (Type,	Print)	56884 BAltim	INDE MA	WILLIAM	01000
	Sta Registr		31. Date liled (Month, Day, Year) APR 102	UNENDAY (0) 32. Pegistrar's Signal	ture	arte) Urili'ill	UNG, NIAN	YIAND	2100/

			•	r pe or Print in t State of Marylar				-	_	
		•	For State Registrar	State of Marylar		tificate of L			2006	12985
	agi:		Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physici /Medic		Gloria	J .	Nappi		A	pril 5, 20	Day Year 006	3:50 A M
	Examin		4a. Facility Name (If not institution, give str	eet and number)			Location of Death		4c. County of Dea	
			Southern Maryland Hospi			Clinton If Under 1 Year	If Under 24 Hrs.		Prince Geor	
	Funeral Director		377 40 0130	7. Age (In yrs. 78	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Nov. 4, 19	9. Bi 927 Ar	nthplace (State or Foreign Country) Kansas
	Maryland I-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince George		ny.Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 No
	3e or 28e	i Direc	10e. Street and Number 3211 28th Parkway			10f. Zip Code 20748		10	g. Citizen of What C USA	Country?
920	be filed within 72 hours after deeth with the Maryland tall Hygiene. do other than "natural", or itame 23a or 28a-f ehow event, the Medical Exertinal trait the incitied at	by Funeral Director		. Was Decedent Ever in U Armed Forces? 1 ☐ Yes X \(\bar{L}\) No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2000 No	spanic Origin? (Spe n, Mexican, Puerto I Specify:	city Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
Baltimore, Maryland 21215-0036		Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)		(Give	dent's Usual Occupa kind of work done o DO NOT use retired temaker	turina most of workir	ng 1	6b. Kind of Busines in Home	·
yland 2	d 2 should be filed within th and Mental Hygiene. ?? Is marked other than treumatic event, the Me	To Be Co	17. Father's Name (First, Middle, Last) Charles E. Hartman				18. Mother's Name Loretta	(First, Middle, M Campbell	aiden Sumame)	
, Mar	s 1 and 2 should f Heelth and Men Item 27 is marks other treumatic		19a. Informant's Name/Relationship (Type Joseph M. Nappi / Hus			•	and Number or Rura ny Temple Hi			
more	Pages 1 gent of He nt: If Item ry or other		20a. Method of Disposition XIXI Burial 2 □ Cremation 3 □ Red 4 □ Donation 5 □ Other (Specify)	noval/from State	cemetery, crer	sition (Name of natory or other place on Cemetery			oc. Location - City of Linton, Mar	
Baltii	permit. Pages 1 and 2 Department of Heelth a Important: If Item 27 is any injury or other tre		21. Signature of Funeral Service Licensee	h,		2. Name and Address	ss of Facility Geor L1 Road Oxor		as Funeral F	
	Physician		23a Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition	cause on each line	th. Do not ent	er the mode of dyin	g, such as cardiac o	r respiratory arre	st,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):	Hyperte	Heart			
,092	ite be executed sysicien and he burial-transit	ical Examiner	Sequentially list conditions if any, leading to immedia/cause. Enter Underty/Cause (Disease or in, that initiated events resulting in death) Last	Due to (or as a consec						
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death. To the Funerel Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	b. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	aldeath 3[Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
ds, P	uires that signed t	ρ	Part II. Other significant conditions contribute of the Period Va	scular di	sease	, veno	US	23e. Did toba		to the cause of death? Probably 4 Unknown
of Vital Records,	The law requir te has been s age 2 should	Completed	gout, Lyp			of le	9,	24a. Was an autopsy perform	ed2 prior to death?	autopsy findings available completion of cause of
ita	lan:	BeC	25. Was case referred to medical examiner?				26. Place of Death			
of V	hysic his ce il direc	ToE	1 ☐ Yes 2 No	spital: 1 Inpatient 2			4 INUISING HOI		nce 6 Other (Sp	ecify)
iono	ath. r: After t	atlon:	27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work	/ at <br Yes 2 □ No	28d. Describe hov	w injury occurred	
Division	al or Atte s efter de si Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci		reet, factory, office	-	28f. Location (Stre City or Town,	eet and Number or I State)	Rural Route Number,
	To the Hospital or Attending Physician: The within 24 hours eiter death. To the Funerel Director: After this certificete his completely filled in by the funeral director, page	Medicai (29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examine	cian: To the best of my knir: On the basis of examination and manner stated.	owledge, deat ation and/or in	h occurred at the tim vestigation, in my op	ne, date and place, a pinion, death occurre	and due to the car ed at the time, da	use(s) and manner attended to and place, and du	as stated. ue to the cause(s)
)	To the within To the Comp	W	29b. Signature and title of certifier R. Sundhua	n'		29c. License	o 0 6 6 6 1 4		d. Date signed (Mor	
	0/00		30. Name and address of person who com	pleted cause of death (Item 4 Y RD-, C	m 23a) (Type, L/N70/	Print) R. SIA	DHWAND	2073	?5	
v.	Sta Registi		31. Date filed (Month, Day, Year) APR 0 6 2006	32. Registrar's Sign						

ORIGINAL

			1 - For State Registrer	State of	Marylan		artment rtificate			and M	-	giene	000	12986
	Physici		1. Decedent's Name (First, Midd) Joseph B.	-,,	al						2. Date of De April		^y 2006 ^{Year}	3. Time of Death 12:18PM
	/Medio Examir		4a. Facility Name (If not institution	n, give street and numb			4b. City, T	Town, or		of Death	P	40	. County of De	ath
	Funeral		12140 Ell La 5. Social Security Number	6. Sex 7	. Age (In yrs.	last birthday)	If Under	1 Year	If Under:		8. Date of Birt	th	Charle 9. B	irthplace (State or Foreign
	Director		217-28-8484 Usual Residence of Decedent	1 % M 2□ F	74	Yrs.	Months	Days	Hours	Min.	(Month, Da Feb. 2		932 M	aryland
	aryland show	_	10a. State 10b. County MD Char		1	y, Town or Lo			_					10d. Inside City Limits
	r 28e-f	recto	10e. Street and Number	res	VV	aruor	10f. Zip (Code				10g. Cit	tizen of What C	1 XYes 2 No
	s 23a o	raiD	12140 Ell La		-			060					USA	
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural, or Itams 23a or 28e-f show any injury or other traumatic avant, its Medical Eriair act must be notified at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marri 3 ☒Widowed 4 □ Divorced	ied 12. Was Deced Armed Forc 1 XYes 2 If Yes, Give Year or Date	ent Ever in U. es? 可炒/7/ en:0/6/	52 54	Was Decede f Yes, speci 1 ☐ Yes 2			gin? (Spe , Puerto I	cify Yes or No Rican, etc.)		14. Race - Arr. Black, Wh Specify:	
21215-0036	in 72 h n "natu estical	pietec	(Specify only higher	st grade completed)		16a. Deced	dent's Usual kind of work DO NDT use	k done di	urina most	of working	ng	16b. K	ind of Busines	s/Industry
1212	lled with tygiene her tha	Com	Elementary/Secondary (0-12) 12	College (1-4	ior 5+)	В	us D			A 81				cansport.
lanc	uld be fi Aental H rked ot tic avar	To Be	17. Father's Name (First, Middle, Joseph A. I								(First, Middle, McPh		,	
Maryland	d 2 sho th and h 7 is ma		19a. Informant's Name/Relations Theresa Nea.		r								or Town, State,	
	es 1 an of Heal fitam 2 r other		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation		20b. P	lace of Dispo emetery, cren	sition (Name	e of her place)	D	ate	20c. L	ocation - City o	r Town, State
Baltimore,	iit. Pag artment ortant: b injury o		* 4 □ Donation 5 □ Other (S	pecify)	MD		rens . Name and			/12				am, MD
Ba	permi Depa impo any ii		Ily &		191	2	0605	Αqι	uasc	o Ro	d. Aqu	asc		ome,P.A. 20608
	Physician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a	R &	SPIR	ATOI	27	F.	Aile	JRE.			Approximate Interval Between Onset and Death F & DITY
	Examiner put put put put put put put put put put	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or	4 RO NO AS as a consequ	uence of):	BSTR S	Lect.	70E	PU	CHONA	RT .	DXSHSE	FEL MUNTHS
38760,	death certificate be executed e attending physician and ad for use as the burial-transit	dicai	resulting in death) Last	Due to (or	as a consequ	uence of):								
P.O. Box 6	that the death certifice ned by the attending ph detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2 ☐ Fetal nt at time of de	death 3	Ectopic pre						23d. Date of de Month	plivery Day Year
	The law requires that the ate has been signed by the page 2 should be detached.	by	Part II. Other significant condition	ons contributing to deal	th but not resu	ulting in the ur	nderlying car	use giver	n in Part I.			bacco u	_	o the cause of death? robably 4 @Unknown
al Records,	: The taw re cate has be , page 2 sho	Completed									24a. Was autop perfor	sy med?	24b. Were a prior to death?	utopsy findings available completion of cause of
Vita	ystclan: This certificate	o Be	25. Was case referred to medical examiner? 1 Yes 2 1 No	Hospital:	atient 2 🗆 I	ER/Outpatien	3 DOA		26. Place ³ 4 □ Nur		(Check only of		6 □Other (Spe	acifu)
Division of Vital	Jing Ph	Certification; T	27. Manner of Death 1 Autural 5 Pendin 2 Accident investig	28a. Date of (Month, gation		28b. Time of Injury		c. Injury a Work?		2	8d. Describe h			iony
DIX:	i di di	Sertific	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 288. Place of	Injury - At ho , etc. (Specify	me, farm, stre	et, factory,	office		2	8f. Location (S City or Tow	itreet an n, State	d Number or R)	ural Route Number,
	To the Hospital or At within 24 hours effer of To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifyin (Check only one) 1 Medical	g Physicien: To the be Exeminer: On the basi and manner	is of examinat	wledge, death ion and/or inv	occurred at estigation, i	t the time n my opi	, date and nion, death	place, a	nd due to the o	ause(s)	and manner a place, and du	s stated. e to the cause(s)
	To t To t	2	29b. Signature and title of certifier	· D	1)-	4 4-1		License		7	2	29d. Dat	e signed (Mon	
	4:1		30. Name and address of person	who completed cause	of death (Item	23a) (Type, I		, , ,		> Was	hingto	on I	/ //	-
	Sta Registr		31. Date filed (Month Pay, Year)		istrar's Signat		Con Contract of the Contract o							

			i icase i	State of Mary					•	
			T= For State Registrar	Clate of Mary			of Death		100 0 0 6	12987
			Decedent's Name (First, Middle, Last)					2. Date of Dea	th	3. Time of Death
	Physic /Medi		Wesley Robert Osb	orne				April	10 200	6 09:39 M
	Exami		4a. Facility Name (If not institution, give	street and number)		4b. City, To	wn, or Location of Dea	ath	4c. County of D	
	4 3 1		Washington County	Hospital]	Hagerstown	Wash	ington County	
	Funeral		5. Social Security Number 6. Sex	7. Age (Ir	yrs. last birthday) 84 Yrs.		year Il Under 24 Hr Days Hours Mir	n. (Month, Day	, rear/	ington County Birthplace (State or Foreign Country)
	Director		185-12-9585 Usual Residence of Decedent	1	04 113.			Oct 31	1921 Pe	ennsylvania
	yland		10a. State 10b. County	10	c. City, Town or Lo	ocation				10d. Inside City Limits
	the Marylar 28a-f ehow	ctor	Maryland Washing	rton	I	Hagerst	own			1 □Yes X□No
	or 28	by Funeral Director	10e. Street and Number			10f. Zip Co	ode		0g. Citizen of What	Country?
	ath w	rai	106 Greenwood Dr				21740		U.S.A	۸.
	er de	nue		 Was Decedent Ever Armed Forces? 	r in U.S. 13. 8–17–42	Was Deceden If Yes, specify	t of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ai Black, W	mencan Indian, hite, etc.
36	rs aft	oy F	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced			1□Yes 2🏋	No Specify:		Specify:	White
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itema 23a or 28a-f ehow ita Modical Examinar musi ce notified at		15. Decedent's Edu	cation	16a. Dece	dent's Usual C	Occupation		16b. Kind of Busines	ss/Industry
215	hin 7.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work o DO NOT use i	occupation done during most of wo retired)	orking		our maddiny
	buld be filed with Mental Hygiene arked other than atic event, the	Son	12		I	older	Man		Book Bind	ling Company
nd	tal Hy d oth	Be	17. Father's Name (First, Middle, Last)					ame (First, Middle,	,	
Уlа	should ind Men inarke umaric	မ	Riley I. Osborne					Wilt Osk		
Maryland	12 sho h and 7 Is my		19a. Informant's Name/Relationship (Ty) Margie Amick Osbo				treet and Number or R rood Drive			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mantal Hyglene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-1 ehov amay injury or other traumatic event, the Miscigal Examinar must be netitied at anging.		20a. Method of Disposition		Ob. Place of Dispo	The second secon			20c. Location - City	
Baltimore,	Pages nent of h ant: if Ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ R		cemetery, crei	natory or other	r place)			y Pennsylvania
Ħ	permit. Page Department of Important: If any injury or 2008.		4 ☐ Donation 5 ☐ Other (Specify) 21 Figure of Funeral Service License							neral Home
Ba	Depared Important Importan		() una la -l	Tim						ryland 21742
	- A	1	23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the						Approximate
4	Physician		Immediate Cause (Final			Arto	T'	(2656		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a co	nsequence of):		ry Di			
	Examiner		Cognostially list conditions	Clost.	ridiun	a di	fficile	Diann	ha	
160	p ##	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	nsequence of):	- 1	fficile Mation			
	and trans	Examiner	Cause (Disease or injury that initiated events cresulting in death) Last	Ata		f : pa	Malion			
760,	The law requires that the death certificate be executed te has been signed by the ettending physician and page 2 should be detached for use as the burial-transit	cai E		Due to (or as a co	nsequence of):					
687	phys phys s the		_ d							
×	certif nding use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	Bc. If yes, outcome of pr	regnancy				02d D-1	
Вох	death e etter	ciar	in the past 12 months?	1 Live birth 2 ☐ 4 Pregnant at time	Fetal death 3	Ectopic pregn Other (specif			23d. Date of d Month	Day Year
P.O.	t the by the ache	hys	9 Unknown	9□ Unknown						
S, F	res that the de signed by the e be detached		Part II. Other significant conditions con	tributing to death but no	t resulting in the u	nderlying caus	e given in Part I.	23e. Did tob	acco use contribute	to the cause of death?
Records,	w require been sig should b	Completed by	Hypen	etes 1	` '			1 🗆 Ye	s 2 □ No 3 □ I	Probably 4 Onknown
ec.	as be 2 sh	ple	Diab	etes 1	nel. t	35		24a. Was a		autopsy findings available
		Con						perform	ned? death?	completion of cause of es 2 No
Vital	cian: ertific ector,	Be (25. Was case referred to medical examiner?					ath Check only on		
of		2	1 ☐ Yes 2 ☐ No		2 ER/Outpatien			Home 5 ☐ Reside	nce 6 Other (Sp	necify)
'n	ding Figh.	in o	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time of Injury		Injury at Work?	28d. Describe ho	w injury occurred	
isic	or or	icat	2 Accident investigation 3 Suicide 6 Could not be	20a Place of laive	At home from the		1 ☐ Yes 2 ☐ No	206 1		
Division	or Attend after death Director: A	Certification:	4 Homicide determined	28e. Place of Injury - building, etc. (S)	pecify)	et, factory, on	rice	City or Town	reet and Number or I , State)	Rural Route Number,
	spita iours neral		29a. Certifier 1 Certifying Phys	ician: To the best of my	/ knowledge, death	occurred at th	ne time, date and place	a and due to the ca	use(s) and manner	as stated
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the tune.	Medicai	(Check only 2 Medical Examin one)	er: On the basis of examination and manner stated.	mination and/or inv	estigation, in	my opinion, death occi	urred at the time, da	ite and place, and du	s stated. Se to the cause(s)
	To the within To the Comp	×	29b. Signature and title of certifier	A			cense number		d. Date signed (Mor	nth, Day, Year)
			fame mul			1	06039	6	04/10/	06
	_		30. Name and address of pers in who cor	npleted cause of death	(Item 23a) (Type,	Print)	S (2)	10	7	
SH	-5+1		an privatual	113	26 Ope	1 Cou	rt /	17. M.	1 2/74	10
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 3 20	32. Registrar's S	signature '	1	•	/		

		1 - For State Registrar	State of Marylar		artment of H		Mental Hy	giene	5	12988
Physi	cian	1. Decedent's Name (First, Middle, Last,)				2. Date of De	eath Day	Year	3. Time of Death
/Med		GLORIA ASSUNTA OU					Apri1	4, 2006		2:20 p M
Exam	iner	4a. Facility Name (If not institution, give			4b. City, Town, or		ath	4c. County		
		1685 Heather Lane 5. Social Security Number 6. Sec		last hirthday)	Hunting	LOWN If Under 24 Hr	s. 8. Date of Bir		lver	
Funera Directo			м 2№ 79	Yrs.	Months Days	Hours Mi		av. Year)	Cou	place (State or Foreign intry) ryland
P.		Usual Residence of Decedent						, 2,110		- Juliu
anylar	-	10a. State 10b. County	10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits 1 X Yes 2 No
he M 28a-f	Director	Maryland Prince G	eorge's Bla	densbu:				40. 000		
with a or 3		10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Cou	intry?
leath na 23	Funerai	5600 Tilden Road	12. Was Decedent Ever in U	.S. 13.	20710 Was Decedent of H	ispanic Origin? (Specify Yes or No	U.S.A.	e - Ameri	ican Indian.
6 after o	표	1 Never Married 2 Married	Armed Forces? 1 ∐Yes 2∭No		Was Decedent of H f Yes, specify Cuba		erto Rican, etc.)		k, White	, etc.
ours a	l by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2Å No	Specify:		Specify	· Wh:	ite
1215-0036 within 72 hours after death with the Maryland ene. than "natural", or Itama 23a or 28a-f show in Mudical Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grade	cation e <i>completed)</i>	(Give	dent's Usual Occupa	during most of w	orking	16b. Kind of Bu	usiness/lr	ndustry
Maryland 21215-0036 and 2 should be filed within 72 hours aff the and Mental Hygiene. 27 Is merked other then "natural", or rerumatic event, the Medical Example traumatic event, the Medical Example.	mp	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired	1)		0 77		
d Z filad Hygie ther		17. Father's Name (First, Middle, Last)		Homem	aker	18. Mother's Na	ame (First, Middle	Own Hon		
ld be ental	To Be	John Anthony Gras	so				ice Marga		,	מר
Should Mind Mind Mind Mind Mind Mind Mind Min	-	19a. Informant's Name/Relationship (Ty		19b. Mailir	ng Address (Street a					
Mind 2 alth a alth a 127 la		Robert A. Ourand	- Son	1685	Heather	Lane, H	untingto	wn, Mary	1ano	1 20639
Ore of He ritam		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ R	20b. F		sition (Name of natory or other plac		Date	20c. Location -		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is merked other then "natural; or Itama 23a or 28a-f show any injury or other traumatic event, the Mudical Eventher must be notified at		'4 □ Donation 5 □ Other (Specify)	ionioval noni State	ropolit	an Cremato	ory 4/6				Virginia
Ball permit Depart Import	ġ	21. Signature Funeral Service License	99		. Name and Addres					
m	N C	23a Part1. Enter the disease, or compli	5 110137		739 Balti	· · · · · · · · · · · · · · · · · · ·			MD	
Pnysiciai /Medica Examine	r	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line. Luny Cancer Due to (or as a conseq	uence of):	or the mode of dynn	g, such as cardi	ac or respiratory a	11631,		Approximate Interval Between Onset and Death 4 Months
acuted ind transit	Examiner	if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	Due to (or as a conseq							
8760, cate be executed obysician and the burial-transit	dicai Ex	resulting in death) Last	Due to (or as a conseq	uence of):						
O. Box 6 ne death certific the attending p thed for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date Mor		ery Day Year
rds, P., quires that the n signed by uld be detac	ed by Ph	Part II. Other significant conditions cor	ntributing to death but not res	ulting in the ur	nderlying cause give	en in Part I.				the cause of death?
	Completed						24a. Was auto perfo	osy primed? d	rior to co leath?	opsy findings available empletion of cause of
r VITAI K ysician: The is certificate ha director, page	Be (25. Was case referred to medical examiner?					eath (Check only o			Sone
on of ding Phys. After this funeral di	ation: To	1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	lospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injury Work	at		dence 6 XOthe		W)Residence
P Pige	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, str	eet, factory, office		28f. Location (. City or To	Street and Numbe wn, State)	er or Rura	al Route Number,
To the Hospital or within 24 hours after To the Funeral Direction	edical	29a. Certifier 1 \(\) Certifying Physical (Check only one) 2 \(\) Medical Examination	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the time restigation, in my op	ne, date and place pinion, death occ	ce, and due to the curred at the time,	cause(s) and mad date and place, a	nner as s and due t	stated. o the cause(s)
To t To t	Σ	29b. Signature and title of certifier	un		29c. License			29d. Date signed	(Month,	Day, Year)
\bigcirc		1 lupel	MD		D0050	951		April 6	, 20	06
2 (3)		30. Name and address of person who co				D. I	1 1			
9	A m A	Reva S. Gill, MD 31. Date filed (Month, Day, Year)	6510 Kenilwo:			, River	dale, Mai	ryland 2	0737	-1346
S Regis	tate trar	APR 0 6 2006	2. Registrar's Signa	Spine	B					

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene

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Cine.	U	63	22	

12020

		For State		Ce	rtificate of	f Death		F	leg. No.	2000	160
Physician/ al Examine	1	Decedent's Name (First, Midd BERNARD	ole,Last) OFFUTI					2. Date of Dea Month April 2, 20	ith Day	Year	3. Time of Death 16:24
*	4	a. Facility Name (if not instituti Prince George's Hos	_	umber)	4	4b. City, Town, Cheverly	or Location of De	eath	ì	County of Death nce George	's
Funeral Director		5. Social Security Number 578-15-6991	6. Sex	7. Age (In yrs.	ast birthday)			Min.		Cou	nplace (State or For ntry) RLEA , W
ow any		Jsual Residence of Decedent Oa. State 10b. County	1		, Town or Locati						10d. Inside City Lim
Maryland 28a-f show d at once.	5	D.C.		W.A	SHINGT	-,			10g. Citizen of What Country?		
ith the Maryland 23a or 28a-f sh notified at once		0e. Street and Number $4027 \ \mathrm{WHEEI}$	ER RD. S	.E.		10f. Zip Code 200			J	n of What Coun USA	try?
or items must be			Married 12. Was De Armed F 1 Yes ivorced If Yes, Give Ye or Dates:	2 X No		es, specify Cul	Hispanic Origin? pan, Mexican, Pu No spec <i>ify:</i>	(Specify Yes or No erto Rican, etc.)		White, etc.	an Indian, Black, ACK
Id be filed within 72 hours after dental Hygiene anrked other than "natural"; event, the Medical Examiner o Be Completed by	200	15. Decedent's Education (Sp Elementary/Secondary (0-12	ecify only highest gra	de completed) 1-4 or 5+)	most of	working life. Do	pation (Give kind O NOT use retired	of work done durin d)	g 16b. Kin	d of Business/In	dustry
orthin straight	2	12th			STU	JDENT			EI	DUCATION	NC
should be filed within and Mental Hygiene. 7 is marked other thatic event, the Med	3	7. Father's Name (First, Middle BERNARD FL						ame (First, Middle, INTHIA (,	
and 2 should lealth and Me tem 27 is ma traumatic ev	2 1	9a. Informant's Name/Relation		HER				or Rural Route Nu		or Town, State, 20032	Zip Code)
permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum:		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other		rom State	Place of Dispos crematory or oth DAR HI	her place)		Date 4-11-06		cation - City or T	
permit. F Departme Importal injury or		21. Sona re of Funeral Servi		41	A 22. N	lame and Addr	ess of Facility		PITO	OL MOR	
nysician Medical caminer		Part I. Enter the disea le, failure. List only one audimmediate Cause (Final diseasor condition resulting in death)	e on each line. se a. Gunshot V	7	Head and		ng, such as cardi	ac or respiratory an	est, shock	x, or heart	Approximate Inter Between Onset a Death
ed nsit Examiner	LAGIIIIII	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus (Disease or injury that initiated events resulting in death) Last	e c	a consequence of							
e be executed ysician and burial - transit		UNPENDED	d. AMENDED								
ath certificat attending phy or use as the	מוכומות ב	F FEMALE: 3b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 U	the 1 Live	outcome of preg birth nant at time of do lown	2 Fe	etal death her (Specify)	3 Ectopic pre	egnancy		Date of delivery Ionth D	ay Year
ires that the de signed by the be detached f	2	Part II. Other significant cond	itions contributing t	o death but not	resulting in the u	underlying caus	se given in Part I.				he cause of death?
ng Physician: The law requires After this certificate has been signeral director, page 2 should be n: To Be Completed	ni biere										opsy findings availa empletion of cause of
ysician: The l this certificate l director, page		25. Was case referred to medic	al			26.PI	ace of Death (Ch			1 🗸	2
sicia is cer lirect	בֿ ב	examiner?	Hospital: 1	Inpatient 2	ER/Outpatient		Other		Residence	e 6 Other:	
nding Phys th. The After thi e funeral di	- /	1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pe	nomu	of Injury h, Day,Year)	28b. Time of In	njury 28c. I	njury at Work? Yes 2 • No	28d. Describe	how injury		
ospital or Attending hours after death. meral Director: Afte y filled in by the fune Certification:	ב ב	2 Accident Inv 3 Suicide 6 Co	restigation Apr 2, 2 uld not be 28e. Place	ce of Injury - At h	15:25 ome, farm, stree			28f. Location (State)		al Route Number, C
24 hours a 24 hours a Funeral I etely filled) ,	29a. Certifier 1 Certifying	Physician: To the be caminer: On the basis and manner:	of examination a				and due to the cau	se(s) and i		ed.
dithin di			,	3-100 T T T T T T T T T T T T T T T T T T		29c. Lice	ense number		29d. Da	te signed (Mon	th, Day, Year)
To the Hos within 24 h To the Fur completely	2	29b. Signature and title of certif	Hall	lai		Ο.	C.M.E.		April :	3, 2006	
othor within To the comple	2	Card C 80. Name and address of person	Hall				C.M.E. more, MD 21	1201	April :	3, 2006	

DHMH 17 Rev 1/2001 OCME 10/2003

			1- For State of Maryland		artment of H tificate of I			ene g. No.	12990
	° Physici /Medic		Decedent's Name (First, Middle, Last) Charles H. Owens				2. Date of Death Month April 9,		ear 7:20 p M
4	Examir		4a. Facility Name (If not institution, give street and number) Continuum Care at Sykesville		4b. City, Town, or Sykes	Location of Death		4c. County of	
	. Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 220–36–5200	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) Mar 21,		. Birthplace (State or Foreign Country) Iarvland
	ryland thow		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Lo		i atomator			10d. Inside City Limits
	h the Ma or 28a-1 s	Funeral Director	Maryland Baltimore 10e. Street and Number	·	10f. Zip Code	eisterstor		g. Citizen of Wha	1 ☐ Yes 2 ☑ No at Country?
	ath wil	ralD	13819 Hanover Pike #4			21136		USA	
036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Itams 23s or 28a-f show event. The Medical Examers in that the invilled at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates:	11	Vas Decedent of Hi Yes, specify Cuba □ Yes 2점 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc. White
215-0036	"natur	leted	15. Decedent's Education (Specify only highest grade completed)	(Give I	ent's Usual Occupa	turing most of work	ing 16	6b. Kind of Busin	ess/Industry
2	filed within Hygiene. Ither than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		s Driver)		School	System
Maryland		To Be (17. Father's Name (First, Middle, Last) Charles H. Owens, Sr.				e (First, Middle, Ma nown''	aiden Sumame)	
Mary	2 sho and Is m	-	19a. Informant's Name/Relationship (Type, Print)				al Route Number, C stminster		
	1 and Health	1 80		of Dispos	sition (Name of patory or other place			Oc. Location - Cit	
Baltimore,	permit. Pages Department of I Important: If ite any injury or of		'4 □ Donation 5 □ Other (Specify) South	h Car	roll Cre	natory 04	2006	Winfiel	
ä	Depa Impo any i	(21. Signature of Funeral Service Licensee M01191		Name and Addres	Lily	ers—Durbo Westminst	oraw Fun ter, MD	eral Home 21157
	/Medical Examiner	ner	23a. Part) Enter the disease, or complications that caused the death. Disease, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	ce of):		2017	or respiratory arrest		Approximate Interval Between Onset and Death
68/60,	ficate be executed physician and is the burial-transit	edical Examin	Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence d	267 :0 0/S	5				
C. BOX	I the death certificate to by the attending physicached for use as the bached for use as	hysiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown	_	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
ecords, P	law requires that lhe de as been signed by the 2 should be detached	by P	Part II. Other significant conditions contributing to death but not resulting	j in the un	derlying cause give	n in Part I.			te to the cause of death? Probably 4 Driknown
Ľ	The lav	Completed					24a. Was an autopsy performer	d? prior	e autopsy findings available to completion of cause of h? Yes 2 \(\text{No} \)
Vital	ysician: is certific director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 10 Hospital: 1 Inpatient 2 ER/C	Outpatient	3□ DOA Othe	26. Place of Death	n <i>(Check only one)</i> me 5 ☐ Residenc	on 6 DOthor (6	Engarita)
io uoi	ding Ph h. After th funeral	atlon: T	27. Mann of Death 1 Invatural 5 Pending (Month, Day Year) 2 Accident investigation	7. Time of Injury	28c. Injury Work		28d. Describe how		ър е спу)
DIVISION	To the Hospital or Atten within 24 hours after deat To the Funeral Diractor: completely filled in by the	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	et, factory, office		28f. Location (Stree City or Town, S	et and Number o State)	r Rural Route Number,
	e Hospi 24 hou e Funer letely fill	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated.	ge, death and/or invi	occurred at the time estigation, in my op	e, date and place, a inion, death occurre	and due to the caused at the time, date	se(s) and manne and place, and	r as stated. due to the cause(s)
	withir Comp	Me	29b. Signature and title of tertifier	ワ	29c. License	0 0 5 4	218 290.	Date signed (M	onth, Day, Year) 0 - 0 6
1	2 7	ı	30. Name and address of person who completed cause of death (Item 23a	i) (Type, P	rint) V49 Mal	calm c	hin, h	lest m	1mter MB 21157
	Sta Registra	- 1	31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 1 1 2006			,			21157

			1 - For State Registrar	State of	Marylan	-	artmer <i>rtificat</i>			nd M	ental Hyg	giene Reg. No.	06	2991
	the affect		1. Decedent's Name (First, Middle, L	ast)							2. Date of Dea			3. Time of Death
	Physici		Dorothy Jeanet	-a Ohlar							April	08	2006	2.00 pM
E. 300	/Media		4a. Facility Name (If not institution, g		har)		4h City	Town or	Location of	Death	Thir		County of Deatl	3:00 a ^M
	Examir	ıer			001)							40.		
	At At At At At At At At At At At At At A	200	FutureCare Che		. Age (In yrs.	last hinth day.		r 1 Year	rstow.		8. Date of Birt		Baltir	
	Funeral			1 M 2 M F			Months		Hours	Min.	(Month, Da)	y, Year)	Coi	nplace (State or Foreign untry)
	Director		187-07-7623 Usual Residence of Decedent		8	6 '''	July 0.						919	PA
	and *		10a, State 10b. County		10c. Cit	ty, Town or Lo	cation					-		10d. Inside City Limits
	ary is	<u>_</u>		roll	100.01	•	sburc	τ.						1 Tes 2 No
	Ba-f	ctc	710			T 1111	bourg	, 						1 163 2 200
	9 cr 2	Director	10e. Street and Number				10f. Zip	Code				10g. Citi:	zen of What Co	untry?
	th w	al	2715 Sandymount	Road				21	048				USA	
	be filed within 72 hours after death with the Maryland ital Hygiene. dother than "netural", or Iteme 23e or 28e-f show event, I're Medical Everting must be rotilling at	Funeral	11. Marital Status	12. Was Deced		.S. 13.	Was Dece	dent of Hi	spanic Orig	in? (Spe	cify Yes or No- Rican, etc.)	. 1	14. Race - Amer	
9	after or Ite	F	1 Never Married 2 Married	1 ☐ Yes 2	No		_			Fuerto	nican, etc.)		Black, White	
8	urs a	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dat	es:		1 🔲 Yes	2L XN o	Specify:				Specify:	White
9	2 ho	Completed	15. Decedent's			16a. Dece	dent's Usu	al Occupa	ation			16b. Kir	nd of Business/I	ndustry
12	n n	ple	(Specify only highest g			(Give	kind of wo	ork done a ise retired,	luring most)	of workii	ng			
7	within ene. then "	E	Elementary/Secondary (0-12)	College (1-4	tor 5+)		Tax I	11771 G	ion			Stat	e of Ma	brelyr
D	e filed within al Hygiene. other than vent, the Me		17. Father's Name (First, Middle, Las				1025 2	7111		's Name	(First, Middle,			ary ranka
/lan	should be ind Mental marked o	To Be	Wilbur Price, Si								len McD		· ·	
Maryland 21215-0036	2 2 2 2		19a. Informant's Name/Relationship Robert Ohler, Ji								l Route Numbe F inks bu		Town, State, Z	
			20a. Method of Disposition			 Place of Dispo cemetery, crei	sition (Na	me of		-	72006		cation - City or 1	Town, State
Baltimore,	permit. Pages Department of I Important: If It eny injury or o		1 ∑Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	eify)	Eve	ergree							'inksbur	g, MD
Ba	Departr Departr Importa eny inji		21. Signature of Funeral Service Sic	ali							and Ch Westm			21157
н			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cau	used the deat	h. Do not ent	er the mod	ie of dying	, such as c	ardiac o	r respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final	y one cause on eac	. 1	0 4		. 0						Onset and Death
	/Medical		disease or condition resulting in death)	a. Cere was throm no 2, 3										
	Examiner			Due to (or as a consequence of):										
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Вох	the death certific y the ettending p iched for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregna							2	3d. Date of deliv	/erv
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	ital or rs afte al Dir led in	Certification:												
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	ledical	29a. Certifier 1 Cartifying F (Check only one) 2 Medical Exa	hysician: To the b miner: On the bas and manne	is of examina	tion and/or in	estigation/	, in my op	inion, death	occurre	id at the time, d	late and	place, and due	to the cause(s)
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	1.55		mandana 5	hahba	121	2	5 m	ain :	5 Trees	7 7	200	Rais!	1erTour	MU 21136
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year рМ Leon Burks Owens April 09 2006 1:15 /Medical 4a. Facility Name (If not institution, give street and number) Ctr 4b. City. Town, or Location of Death 4c. County of Death Examiner Westminster Nursing and Convalescent Westminster Carroll 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X**îM 2□ F Director 225-26-6905 82 19 1923 July VA Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Maxical Eya of that is ust be notified at MD Carroll Westminster Director 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 88 Timber Ridge 21157 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 □ ¥es 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after on and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Š Specify 3 ₩ Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Diamond Cab Company Cab Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Burks Owens Ethel Rorrer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 siment of Health an 3008 Vermont Avenue Baltimore, MD Robert Owens/brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 4/10/2006 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or injury or 4 □ Donation 5 □ Other (Specify) Carroll Cremation, Inc Hampstead, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Pritts Funeral Home and Chapel, P.A. au 21157 412 Washington Road Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to burial-transit ре ехесп Due to (or attending physician for use as the burial Division of Vital Records, P.O. Box 68760 parosis with Amening Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Dinknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 ☐ Yes 2 🗔 NO completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No P 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manne eath 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending 1 Matural 5 Pending investigation death. 2 No 2 Accident after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signarore and t 29d. Date signed (Month, Day, Year) WIL Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 inal calmalure, West mingter MD 21157 aneug 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 11 2006 Registrar

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21215-0036	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23e or 28e-f show any highty or other traumatic event, it a Medical Examical must be notified at ance.	by Funeral Director	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	If Was Give	955-	Was Deced If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spec , Puerto R	rfy Yes or No- ican, etc.)	14. Race - Ame Black, Whit Specify: Wh			
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			30. Name and address of person who cor		m 23a) (Type, I	Print)								
11)	754		ZAFAR A. ANSARI, MD		FFICE B	D. WA	LDOR	F.MD.	20	602				
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician Oliver** 10, 2006 **April** 10:00 a James Ray /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 6914 Carrico Mill Road Hughesville Charles If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 82 1923 Director 579-38-9832 May 16, Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "natural", or iteme 23a or 28a-f ehow tre Medical Examiner must be notified at 1 Tes 2000 Director Maryland Charles Hughesville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6914 Carrico Mill Road 20637 USA Completed by Funeral deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 🕱 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) other then College (1-4or 5+) Heavy Equipment Mechanic 11 Alth and Mental Hyer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thoedore 01iver Margaret Viola Thompson William 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 ment of Health a ant: If item 27 is 6914 Carrico Mill Road, Hughesville, MD 20637 Faye C. Oliver/Spouse injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page:
Department o
Important: If i
eny injury or Trinity Memorial Gar. 4/13/2006 Waldorf, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Libertee rinsfield-Echols Funeral Home .0. Box 128, Charlotte Hall, MD P20622 The deab. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause shock line. Approximate Interval Between Onset and Death Immediate Cause (Final ANCRIVO **Physician** MNE /Medical resulting in death) Due to (or as a consequence of **Examiner** NETAS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physicien Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No page 2 should be detached 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificete has autopsy 1 Yes 2 No or Attending Physician: completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death | Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Peath 28b. Time of After 1 Alatural 2 Accident Injury 5 Pending 1 □ Yes 2 □ No death. investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours efter To the Funeral Dire To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Madical Examiner: On the basis of examiner and manner stated. and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) nd title of certifie 29c. License number 29d. Date signed (Month, Dev. Year) 29b. Signature and address of person who completed caus of death (Item 23a) (Type, Print) 1 0 Per 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 1 1 2006 Registrar

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Immediate Cause (Final disease or condition resulting in death) Examiner				23a. Part1. Enter the disease, or compli	cations that caused the dea							Approximate
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Sequentially list conditions as consequence of program to the past 12 months? The propose and a segregation of the past 12 months? The propose and a segregation of the past 12 months? The propose and a segregation of the past 12 months? The propose and a segregation of the past 12 months? The propose and a segregation of the past 12 months? The propose and a segregation of the past 12 months? The propose and a segregation of the past 12 months? The propose and a segregation of the past 12 months? The propose and a segregation of the past 12 months? The propose and a segregation of the past 12 months? The propose and a segregation of the past 12 months? The past		/Medical		resulting in death)	l		100	J	(F/13/4	0277	
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Due to (or as a consequence of): Due to (or as a consequence of):		p ≓	ner	if any, leading to immediate cause. Enter Underlying		quence orj:						
Section Color Co		ecute and trans	am	that initiated events								
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the contribute to	87	cate t	dlca		J							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the contribute to	9 ×	ding p	/Me		3a If yas autooma of orosa							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the contribute to	Bo	atten for us	lan	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta	aldeath 3 □						livery Day Year
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DIABRES MELLITOS TYPE II 1 yes 2 No 3 Probation of the property of th	Δ.	that led by deta		Part II. Other significant conditions con	tributing to death but not res	ulting in the ur	iderlying ca	ause given	in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
25. Was case referred to medical examiner? 1	ds .	ures sign	D	IA A		YPE I	Ī.			1 🗆 Y	es 2 No 3 P	robably 4 Unknown
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25. Was case referred to medical examiner? 1	Be	nela ehas age 2	Ĕ	DSD LOWER OF		^ <i>T</i> .	· · · ·	<u> </u>		autop: perfor	sy prior to med? death?	completion of cause of
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, D. D. 280.79) April 196	ta '			25. Was case referred to medical	VASCULA	E PI	S 24.		Of Diago of D			s 2□ No
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, D. D. 280.79) April 196	>	ysicii s ceri direct	00	examiner?	ospital:	ER/Outpatien	3 □ DO	Other				noifu)
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29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, D. D. 280.79) April 196	jo :	ath. r: Aft	atlo		(Month, Day real)	injury						
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, D. D. 280.79) April 196	Vis	er de recto by th	tf	determined	28e. Place of Injury - At h	ome, farm, stre	et, factory,	, office		28f. Location (S	treet and Number or R	ural Route Number,
(3) 10 Thannie Chiliss Tupuer BERUTT HAMI 6,2	۵	rs aft rs aft ei Di	Ç		Bullating, old. (Spoot	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				Ony or row	n, State)	
(3) 10 Thannie Chiliss Tupuer BERUTT HAMI 6,2		e nospi 24 hou e Funer etely fill	dical	(Check only 2 Medical Examin	ier: On the basis of examina	owledge, death ition and/or inv	occurred a estigation,	at the time, in my opin	, date and pla- non, death oc	ce, and due to the courred at the time, d	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
(3) 10 Thannie Chiliss Tupuer BERUTT HAMI 6,2		or the state of th	9 - 9	29b. Signature and title of certifier	711 5		29c.	License r	number	2	29d. Date signed (Mon	th, Day, Year)
		131,0	H	Francie C	1.141555- Du	suer (D	2850	77		April 6,	2006
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				30. Name and address of person who co	mpleted cause of death (Iter	23a) (Type, I	Print)					
11700 Brysman Dr. Beyrame, un 200705	-	ye		11700 Paus	MULLE DE	Bec	560	ue.	440	20070	5	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	1994 13.				32. Registrar's Signa	ature		7				

			For 1 - State Registrar		aryland / De		Health and M	lental Hyg	211116	12996
			Registrar 1. Decedent's Name (First, Middle)	o (act)	<u> </u>	ertificate of	Dealli	2. Date of Dea	th	3. Time of Death
2	Physici /Medi Examir	cal	Thomas Edwa 4a. Facility Name (If not institutio	rd Peterson		4b. City, Town,	or Location of Death	Month 04	Day Year 04 06 4c. County of Dea	3:25 A M
	Funeral Director		Holy Cross Ho 5. Social Security Number 578-68-3373	spital	ge (In yrs. last birthda			8. Date of Birth (Month, Day 09-17-	ery thplace (State or Foreign unity) NC	
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	death with the Maryland ims 23a or 28a-f ehow ir intert the modified at	ctor	MD Prince	e Georges	Suitland	ł				1X Yes 2 □ No
	with the	Dire	10e. Street and Number			10f. Zip Code		1	10g. Citizen of What Co	-
	eath rs 23	era	3358 Curtis D	12. Was Decedent		2074		ecity Ves or No-	United Sta	
	s 1 and 2 should be filed within 72 hours after death with the Marylan if Heelth and Mental Hygiene if Heelth and Mental Hygiene interest is marked other then "natural", or items 23a or 28a-1 ehow other traumatic event, it a Medical Exactlinar traumatic event, it a Medical Exactlinar interests inclinated.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ※ Divorced	Armed Forces' ried 1 ☆ Yes 2 □	No.	If Yes, specify Cut	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	Rican, etc.)	Black, Whit	te, etc.
21215-0036	within 72 hor ene. then "naturaline"	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	nt's Education st grade completed) College (1-4or	16a. De (Gi	cedent's Usual Occu ve kind of work done . DO NOT use retire	pation a during most of work ad)	ing	16b. Kind of Business	/Industry
	filed with Hygiene ther the	Com	12		Fac:	ility Supe	1		Potomac Jo	ob Corp
Maryland	ould be fill Mental H arked oth atic even	Be	17. Father's Name (First, Middle,				18. Mother's Name			
ary!	2 should and Mer ie marks aumatic	ည	Thomas Peterso 19a. Informant's Name/Relations	n ship <i>(Type, Print)</i> Dausc	htor 19b. Ma	illing Address (Stree		er Peter	SON r, City or Town, State, .	Zip Code)
, Ma	and 2 sellth at 27 io er trau		LaShawn Peterso	_		3 Jameson	Street, I	emple H	ills, MD 20	0748
Baltimore,	permit. Pages 1 and 2 a Depertment of Heelth ar Important: If Item 27 ie any injury or other trau		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation	3 ☐Removal from State	comotoni c	position (Name of rematory or other pla		Date	20c. Location - City or	Town, State
Iţim	it. Pa		4 □ Donation 5 □ Other (S 21. Signature of Funeral S rvie		MD Vete	rans Ceme	tery 04-10		Cheltenhan	
Ba	Depe Impo		21. Signature of Purierar Save	Han IVa	m ()		Str		Funeral S	
	Physician		23a. Pall . Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on each I	d the death. Do not e	enter the mode of dy			Springs, M est,	Approximate Interval Between Onset and Death 4 years
	/Medical Examiner	J.	resulting in death) Sequentially list conditions,	b	a consequence of):					
,092	eath certificate be executed ettending physicien and for use as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	a consequence of):	_				
	cate b physic the b	dlcal		d						
.O. Box 6	The law requires that the death certifica tie hes been signed by the ettending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death	3 □Ectopic pregnand 5 □ Other (specify) _	Sy .		23d. Date of de Month	livery Day Year
ď.	res that igned b be deta	by Pi	Part II. Other significant conditi	ons contributing to death t	out not resulting in the	underlying cause g	ven in Part I.	23e. Did to	bacco use contribute to	the cause of death?
ord	w require been sign should b	ted	Pancytopenia					1 □ Y	es 2∱2∏No 3∏Po	robably 4 DUnknown
		Completed	Sepsis					24a. Was a autops perfori 1 ☐ Yes	sy prior to med? death?	utopsy findings available completion of cause of
Vital	Physician: this certific al director,	Be	25. Was case referred to medica examiner?	Hospital:		l Ot	26. Place of Death			
ō	Phy this	. To	1 ☐ Yes 2 ☒ No 27. Manner of Death	28a. Date of Inju	ury 28b. Time	of 28c. Inju	4 Nursing no		ence 6 Other (Spe	cify)
ion	Attending r death. ctor: After by the funer	atlor	1 ⊠Natural 5 ☐ Pendia 2 ☐ Accident invest	gation	iy Year) Injun		ork?]Yes 2 □No			
Division	tal or Att rs efter de el Directo ed in by t	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	pined 289. Place of in	jury - At home, farm, tc. <i>(Specify)</i>	street, factory, office		28f. Location (SI City or Town	treet and Number or Ri n, State)	ural Route Number,
	To the Hospital or Attendir within 24 hours effer death. To the Funarel Director: A completely filled in by the fu	Medical (25a Certifier 1X Certifyii (Check only 2 Medical one)	Physician To the best Examiner: On the basis of and manner st	of examination and/or	investigation, in my	opinion, death occurr	and due to the e ed at the time, d	aue (e) and manner ad late and place, and due	e to the cause(s)
	To t To t	Σ	29b. Signature and title of certifie		V 4 . 5		se number		29d. Date signed (Mont	
2	0	Ŋ	20 Name and addition of	unto complete de conse	doub (lton ma) T		3224		April 4, 20	JU6
1	10)		30. Name and address of person Ram S. Trehan,	MD 1400 Fc	rest Glen	Road, Sui	ite 435, S	ilver S	pring, MD 2	20910
	Sta	ite	31. Date filed (Month, Day, Year,		rar's Signature	_				

			1 - For State Registrar	State of N	Maryland		artmen rtificat					Reg. No. UU	16	12997
\ }	Physic /Medi	cal	Decedent's Name (First, Middle, Las Glenna Helton Facility Name (If not institution aims.)	Padgett	el .		45 00	T		- 1 - 1	2. Date of De April	9, ^{Day} 2006		3. Time of Death 11:45 A M
ASS.	Examir	ner	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)					4b. City, Town, or Location of Death Frederick If Under 1 Year If Under 24 Hrs. 8, Date of Birth				Fred	4c. County of Death Frederick	
, 13 , 14	Funeral Director				72	Yrs.	Months		Hours	Min.	8. Date of Bird (Month, Da Feb. 13	, 1934	Vir	place (State or Foreign ntry) ginia
	the Maryland 28a-f show notified at	10a. State 10b. County 10c. City, Town or Location										10d. Inside City Limits 1 ☐ Yes 2₹€No		
9036	o 72 nours alter death with the Maryland "naturel", or tema 23a or 28a-f show solical Exemples outst be netting at	by Funeral Directo	6606 Hunters Trail 11. Marital Status 1 Never Married 28 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 15. Education t grade completed) 16. Deced (Give life. L		21702 Was Decedent of Hispanic Origin? (Specify Yes or f Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ☑ No Specify:			ocify Yes or No Rican, etc.)	10g. Citizen of What Country? United States 14. Race - American Indian, Black, White, etc. Specify: White				
Maryland 21215-0036	d within 72 h giene. er then "netu ire Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)			Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Loan Officer			t of workir	ng	16b. Kind of Business/Industry Banking			
ryland	1.2 should be filed within h and Mental Hygiene. 7 is marked other than "traumatic event, it a Mac	To Be C	17. Father's Name (First, Middle, Last) Dewey D. Helton	Last)			18. Mother's Name			t Snodgrass				
	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur sny injury or other traumatic event, ITE Mudical ODEs.		19a. Informant's Name/Relationship (T) John L. Padgett / 20a. Method of Disposition	Husband	20b. Plac	6606		ers	Trail	. Way		erick, M. 20c. Location	D 21	702
Baltimore,			1 ☐ Burial 2 ② Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Full Service Licen		8	haven	Crem	ator	у	200	06	Frederi		
	世		21. Signature of Fundamental Service Licen 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Onset and Death											
	hysician physician with physician and physician the prival-transit the prival-transit the physician with the physician physici	dical Examiner	Intrindicate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to minediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):											
.O. Box 6	The law requires that the death certific lie has been signed by the attending p. page 2 should be detached for use as i	Physician/Med	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		e of pregnancy 2 Petal de at time of death	ath 3	Ectopic pre					23d. Dai Mo	te of delive	ory Day Year
ords, P.	w requires that been signed by should be deta	by	Part II. Other significant conditions co	ns contributing to death but not resulting in the underlying cause given in Part I.						ie. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown				
		Completed	10							perfor	a. Was an autopsy performed? Yes 2 12 No 24b. Were autopsy findings available prior to completion of cause of death? 1 1 Yes 2 No			
/ision	Attending Frigsto or death. ector: After this ce by the funeral direc	25. Was case referred to medical examiner? 1						lence 6 Oth						
		Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Loc						8f. Location (S City or Tow	ocation (Street and Number or Rural Route Number, ity or Town, State)				
:	To the Hospital or within 24 hours afte To the Funeral Dir.	edical	29a. Certifier 1 ertifying Phy (Check only one)	ner: On the basis and manner s	of examination	dge death and/or inv	estigation,	in my op	a data and inion, deat	h occurre	nd due to the c d at the time, c	tause(s) and ma date and place, a	and due to	ated. the cause(s)
)	- S - O	Z	29b. Signature and title of certifie	Snif m D5.8391					4-	1. Date signed (Month, Day, Year) 4 - 10-06				
2)) Sta Registr	- 4	30. Name and address of perion who co	2,MD	s Signature	Tal	Ho		A	ve.	Fred	leviel	M	D 21701

			For Stata Registrar	State of M	aryland		artment of F		nd Mental Hy	giene Reg. No.	06	1299	98	
			1. Decedent's Name (First, Middle, La	2. Date of Deat				th 3. Tie		Death				
		Medical DALTON WINFRED PERRY							APRIL	7	7 2006 8:0°		P M	
#- X	Examir		4a. Facility Name (If not institution, giv		4b. City, Town, o	or Location of	Death	4c. 0	County of Death					
			FREDERICK MEMORI	AL HOSPIT	AL		FREDERI	CK		F	REDERIC	K		
	Funeral Director	E E 7 0 2 6 0 2 1 / 1 1 1 1 1 1 1 1 1						If Under 2 Hours	Min. 8. Date of Bi (Month, D)	rth ay, Year) 3,193	Year) 9. Birthplace (State or Foreign Country) Connecticut			
	D		Usual Residence of Decedent											
	rylan	_	10a. State 10b. County Maryland Frederic	ale.		Town or Lo urmoni					1	10d. Inside C	ity Limits 2 \(\begin{align*} \text{NO}	
	Ba-1 s	cto			111	ur morr							2 🗆 NO	
	or 2	Ole e	10e. Street and Number				10f. Zip Code				en of What Cou	ntry?		
	ath w	Funeral Director	214 N. Church St	1.0	21788				USA					
	er de		11. Marital Status	13.	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)				 Race - America Black, White, 					
36	rs aft	by F	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ If Yes, Give Year or Dates:			1 ☐ Yes 2 🔀 No	Specify:			Specify: W	nite		
21215-0036	be filed within 72 hours after death with the Maryland stal Hygiene. dother than "natural", or Items 23a or 28a-f show event, the Madical Expriner must be multipled at		15. Decedent's E	ducation	Rolea	16a. Deced	ient's Usual Occup	pation		16b. Kin	d of Business/In	dustry		
215	n n	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or	5.1	(Give life. i	kind of work done DO NOT use retire	during most d)	of working					
212	d within giene. ir than "	E	10	College (1-40)	3+/	Tru	ick Drive	er			Transfe	r		
	othe othe	Be	17. Father's Name (First, Middle, Last,					18. Mother	r's Name (First, Middle	a, Maiden S	Sumame)			
/lar	uld b Menta rrked	10	Jacob A. Perry					Sopl	hia E. Hum	e				
Maryland	d 2 should be filed within h and Mental Hygiene. 7 le marked other than "traumatic event, the Mas		19a, Informant's Name/Relationship (-		r or Rural Route Numb			Code)		
	permit. Pages 1 and 2 should Department of Health and Men Importent: If Item 27 Is marke any Injury or other traumatic once.		Betty J. Perry/ W:	LIE	20h Pla		sition (Name of	Stree	et, Thurmo	-	ation - City or To	own State		
Baltimore,	Pages nent of H ant: If Its ary or of		1 ☐ Burial 2 X Cremation 3 ☐		e cer	metery, crer	natory or other pla	1 /	4/11		,			
ij	artme artme ortent injury		4 Donation 5 Other (Specif		rred		Cremato	ess of Facility Stauffer Fund			rederick, MD			
Ba	permit. Departr Importe any Inju		1 Locum(C)	-					eet Thurmo:			171		
			23a/Par 1. Both rithe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate											
	Physician	show, or heart failure. List only one cause on each line. Immediate Cause (Final										Onset and		
	/Medical		Immediate Cause (Final disease or condition resulting in death) a. Will Non Qurer My landing infanction for the condition of the conditions, b. EM Study Pulmoning fillers is										al g	
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	icate be executed physicien end s the burial-transit	xan	that initiated events resulting in death) Last	cDue to (or a	s a conseque	ence of):				· · · · · · · · · · · · · · · · · · ·				
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89	ificate g phy as the	a a		<u> </u>										
Вох	leath certific attending p	Z	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Ectopic pregnanc			2:	3d. Date of delive	ery		
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant :	at time of dea		Other (specify) _	y 			Month	Day `	Year	
P.0	that the de led by the a detached i	Physician/M	9 Unknown											
	iw requires that s been signed b should be det	þ	Part II. Other significant conditions	II. Other significant conditions contributing to death but not resulting in the und						Did tobacco use contribute to the cause of death?				
ord	equir ould	ted	Hypercholosy	my	nyen	ner	1 1 1	1 ☐ Yes 2 ☐ No 3X Probably 4 ☐ Unknown						
							24a. Was	psy prior to completion of cause of						
X	The rate h	5							pert 1 ☐ Yes	ormed?	death? 1 ☐ Yes	2□ No		
/ita	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has be completely filled in by the funeral director, page 2 s	Be	25. Was case referred to medical examiner?	Manufal					of Death (Check only	one)				
of Vital		2	1 □ Yes 27 No	Hospital: Inpatient 2 ER/Outpatier					ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred					
n C	ling F	ion	27. Manner of Death Natural 5 ☐ Pending				Wo	ryai rk? ∣Yes 2. □N		250. Describe flow injury occurred				
Division	death. ctor: A y the fu	fical	2 Accident investigatio 3 Suicide 6 Could not b		niury - At hon	ne, farm, str	eet, factory, office	1100 2	28f. Location	(Street and	Number or Rura	al Route Num	nber,	
Ö	al or A s after Il Direct	Certification:	4 Homicide determined	building, e	etc. (Specify)		,,		City or To	iwn, State)				
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical C		ninar: On the basis	of examination				d place, and due to the h occurred at the time				s)	
	ithin ithin of the minimum	Med	29b. Signature and title of certifier	and manner s	orated.		29c. Licens	se number		29d. Date	signed (Month,	Day, Year)		
	ک≒≰∸		10.()	11/1	1 That	- /1 -		20	182	13-	110	. 7-	01	
\	AW.		30. Name and address of person who	completed cause of	death (Item	23a) (Tune	Print)	> 2 /	0 0	gon	18	100	06	
0	* 1.		ALT AL	rockte	6 2	00	West	gta	St. F	PAR	f 8	, M	10	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 1 1 2	006 32. egis	trar's Signatu	ire	- A'			-7	,			

Examine or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funerel Director: A completely filled in by the fu

Physician

/Medical

Examiner

Funeral

Director

r then "natural", or Iteme 23s or 28s-f ehow the Madical Examinar must be notified at

Direct

by Funeral

Completed

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

2 2 3	et	(Specify only highest grade completed)		(Give kind of work done	during most of working	100.11	Too. Kind of Dadwiddenia dolly					
within iene. r then	Complet	Elementary/Secondary (0-12)	College (1-4or 5+)	homemake	,		own home					
Hyg the	0	17. Father's Name (First, Middle, Last)			18. Mother's Name (F	irst, Middle, Maiden	Sumame)					
d be antal	<u>m</u>	William G. Dick	kensheets		Rosie	Catherine	Goodwi	1				
mari mat	2	19a. Informant's Name/Relationship (T		19b. Mailing Address (Street								
d 2 s th ar trau		Doris E. Engel/ daughter 10896 Boyer Ave. New Market, MD 21774										
Heal The Heal		20a Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State										
permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "ne eny Injury or other traumatic event, Ita Mulcance.		1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Church of God Cemetery 4/11/2006 Uniontown, MD										
permit. Departi		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hartzler Funeral Home 6 E. Broadway Union Bridge, MD 21791										
		23a. Part1. Enter the disease, or comp	olications that caused the deat	h. Do not enter the mode of dyir	ng, such as cardiac or re	espiratory arrest,		Approximate Interval Between				
Physician		Immediate Cause (Final		MONARY EN	m Bollson		Onset and Death					
/Medical		disease or condition resulting in death)	a. Due to (or as a conseq		17750015771			(101)				
Examiner												
	e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseq	uente of).								
uted f ansit	듵	cause. Enter Underlying Cause (Disease or injury	_									
al-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):			- 1					
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phy:	윷	0.										
Physician: The law requires that the death certificate be executed tribic certificate hes been signed by the attending physicien and rail director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23d. Date of delivery Month Day Year									
by ti	بخ	9 Unknown										
uires th	d by	Part II. Other significant conditions of	ren in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknow								
shounds	lete					24a. Was an	24b. Were au	topsy findings available				
The lav	Completed by					autopsy performed? 1 Yes 2 No	prior to death?	completion of cause of				
ian: ruific ctor.	Be (25. Was case referred to medical examiner?			26. Place of Death (Check only one)							
ysic lis ce dire	ည	1 Yes 2€No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)									
- E - E - E		27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury Wood M 1	yat 280 k? Yes 2 □ No	28d. Describe how injury occurred						
or Atter after dea Director I in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, factory, office by)	Location (Street ar City or Town, State	ocation (Street and Number or Rural Route Number, ity or Town, State)						
he Hospital or Attending the Hospital or Attending the Funeral Director: A pletely filled in by the fu	Medical C	29a. Certifier (Check only one) Check only one) Check only one) Check only one) Check only one) Check only one) Check only one)										
To the within 2 To the complet		29b. Signature and title of certifier	29c. Licens	29c. License number			29d. Date si med (Month, Day, Year)					
		DW59552 4/7/06										
MIL		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1										
3		30. Name and address of person who completed came of death (Item 23a) (Type, Print) 6-OUNISHMANN C. NA GANNA TOO A POOLE NO WESTMINSTER M.D. 2/157										
		31. Date filed (Month, Day, Year)	32. Registrar's Signa		E IL OUL	0 / 0 - //- 0 //2						
St Regist	ate rar		2006 Sincer	· · · · · · · · · · · · · · · · · · ·								
		AFKII	LUUU JURING	N. Tales	7							

State of Maryland / Department of Health and Mental Hygiene 1 - Stete Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** WILLIAM JOSEPH PALMER 12:27 P^M APR 6 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY 8. Date of Birth (Month, Day, Year) March 24,1924 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** Months Days 1**X** M 2□ F 82 Florida Director 262-24-9719 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location item 27 is marked other then "natural", or iteme 23a or 28a-f show other traumatic event, the Mudical Examinar must be notified at 10d. Inside City Limits Y□Yes 2 □ No Prince Georges Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 15718 Pointer Ridge Drive 20716 death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status e filed within 72 hours after at Hygiene "Hygiene" natural", or ite 1 Never Married Married I∐Wyes 2 ☐ No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 58-162 1 ☐ Yes 2X No White ģ Specify: Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US Navy/ FAA 12 Electronics Technician permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth ery injury or other traumatic event <u>90x8</u>. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Violet Christiana Gates Horace Hayden Palmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Johanna M. Palmer/ Wife 15718 Pointer Ridge Drive Bowie, MD 20716 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) MD Veterans Cemetery 4/11/2006 Cheltenham, MD 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 16000 Annapolis Road Bowie, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** SEPSIS /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed ettending physician and d for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No detached the c 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 💹 No 3 Probably 4 Unknown peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificete has autopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🔀 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 🕅 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1X Natural 5 Pending death. investigation M 1 Yes 2 No 2 Accident filled in by the within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospitei 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 1/7/06 D 0063212 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person NATIONAL NAVAL MEDICAL CENTER LAITH ALTAWEEL MD BETHESDA MD 20889-5600 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar